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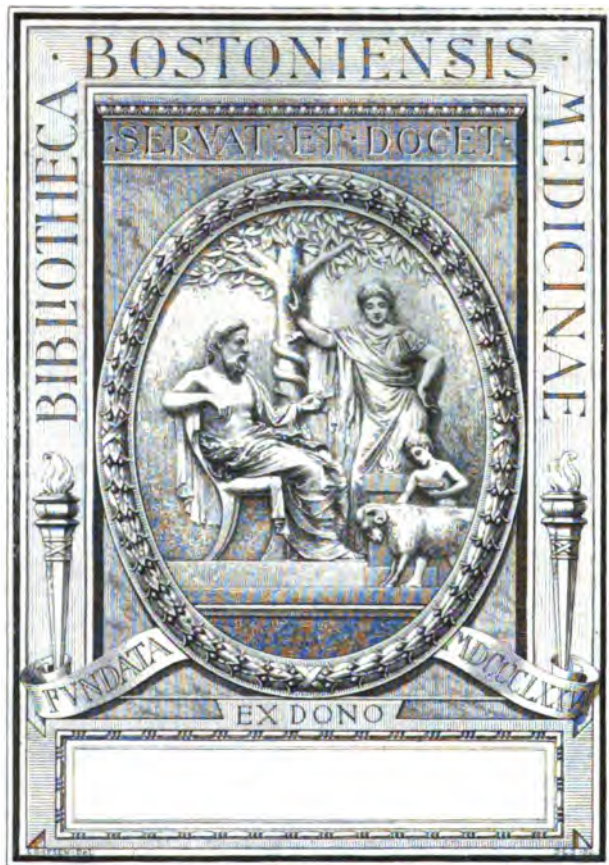
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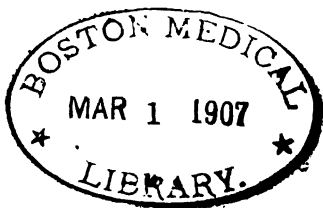
OF

MEDICINE AND MEDICAL AFFAIRS.

FROM JANUARY TO JUNE,

1905.

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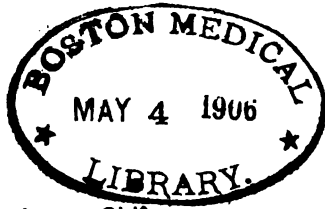
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Original Communications.

ANÆSTHETIC PNEUMONIA.

By WILLIAM MURRELL, M.D., F.R.C.P.,

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OBJECTION may be taken to the use of this term on the grounds that the lung condition is not always the result of the administration of an anæsthetic, and that when it does occur it is not, as a rule, a true pneumonia. In the majority of cases it is a catarrhal bronchorrhœa followed by œdema of the lungs. It is met with most frequently after the administration of ether, but is occasionally seen after chloroform, even when not given by gas or candle-light. I know of no case after nitrous oxide or ethyl chloride. Ether pneumonia may be due to the irritation produced by the anæsthetic itself, to exposure of the patient to cold, especially in prolonged abdominal explorations, and possibly in some cases to the use of a contaminated mouth-piece. It is said to be more common after "anæsthetic ether," sp. gr. 0.717, than after "ether purus," sp. gr. 0.720. At the Westminster Hospital the latter is always employed, and there have been no accidents. Ether excites a hypersecretion of saliva, and as the mouth contains many pathogenic organisms it is conceivable that in deep respiration pneumococci may be drawn into the lungs and set up aspiration pneumonia. It is more common in hospital work than in private practice, possibly because in most hospitals the patient is taken out of a hot operating theatre through draughty passages into a ward, the windows of which are always open. The risk might possibly be obviated by pulling a veil over the patient's head during the process of removal, and by taking him temporarily to a small ward well warmed and free from draughts. In private practice the operation is usually performed in a room at a temperature of 70°, and the patient is well covered with blankets and kept warm with hot-water bottles. The administration of ether lowers the bodily temperature, which, in a prolonged operation, may fall from two to four degrees. The employment of special hot-water operating tables is worth considering, especially when the patient is prone to bronchitis. A well-known anæsthetist attributes the freedom from lung complications in his cases to the fact that he never allows the windows to be opened after an operation. Attention to this point is of some importance, as the friends nearly always want the windows opened in order to get rid of the, to them, objectionable smell of ether. It has been sug-

gested that prior to the administration of the anæsthetic, the mouth, throat and nasal passages should be rendered aseptic by the use of a mouth-wash and gargle, but what is of far more importance is to sterilise the mouth-piece. In the case of a woman, æt. 59, who died with the symptoms of pneumonia on the third day after the administration of five ounces of anæsthetic ether for an operation lasting fifty minutes, the reporter attributed the fatal result, not to the anæsthetic, but to "shock and infection." He stated that he found afterwards that a visitor who was present had come straight from the *post-mortem* room to the operation. Such undesirable visitors should be excluded.

It is difficult to obtain accurate statistics of these cases, partly from the fact that there are many complicating factors which are difficult to eliminate, and to a greater extent to the circumstance that in few hospitals is an "anæsthetic register" kept. A register of anæsthetics, stating the nature of the operation, its duration, the nature and quantity of the anæsthetic employed, and any after-effect observed, would afford useful data for comparison. Many anæsthetists of wide experience have never met with cases of this description, but from statements derived from various sources I am inclined to think that bronchial complications of one kind or another are seen in, roughly, one in fifteen hundred cases of ether administration. A case which attracted some attention not long ago was that of a well-known artist who was operated on under chloroform and a very little ether in a nursing home in London. He apparently recovered perfectly from the effects of the operation and the anæsthetic, but twenty-six hours later there was hypersecretion of bronchial fluid which caused death from asphyxia in less than half an hour. I know, too, by hearsay, of a case in which a similar disastrous effect followed the administration of ether by the rectum for an operation on the larynx. Some years ago I saw in consultation a young engineer suffering from chronic bronchitis and emphysema. His story, and it was confirmed by his doctor, was that two years previously, his teeth being in a very bad condition, he decided to have them removed that a denture might be fitted. On a cold winter's day he went to a dentist's, and was shown into a room without a fire. He was told to remove his coat and collar, and a cold mackintosh was wrapped about his neck. He was placed in a chair opposite a window, from which a cold draught descended like a douche. He had gas and ether, and the operation lasted over an hour. When he

recovered consciousness he was thoroughly chilled and for some time was laid up with acute bronchitis, from which he dated all his subsequent sufferings.

With regard to anæsthetic pneumonia, it should be treated on ordinary principles. The symptoms may make their appearance in from five to seven hours after the operation, or they may be postponed for some days. The cases of hypersecretion present no difficulty, for many years ago it was shown by Ringer and myself, working independently, that atropine was the physiological antidote to this condition, and that it was prompt in its action. The patient should be inverted so as to allow the fluid to run out of the mouth, and he should be given a hypodermic injection of 1-60th grain or more of sulphate of atropine.

Therapeutic Notes.

GLYCOTHYMOLINE AS AN ORO-NASAL AND A GENERAL ANTISEPTIC.

By DAVID WALSH, M.D. Edin.,

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It is only by slow degrees that medical men as a profession are learning to realise the important part played by bacteria in the cavities of the nose and mouth. One sign of this appreciation may be found in the fact that washes and gargles for the mouth and throat are being more and more adopted in everyday practice. The systematic use of such applications, however, so far as the nostrils are concerned, is for the most part still confined to specialists. One reason for this comparative neglect of a simple method of treatment by general practitioners has no doubt hitherto lain in the difficulty of obtaining a safe and, at the same time, an efficient antiseptic and cleansing fluid for the mucous membranes in question.

Glycothymoline was brought to my notice as an excellent lotion for nasal and oral sprays and washes. On due inquiry it was found to fulfil the two conditions usually recognised by medical men in the United Kingdom as vouching for the character, so to speak, of such a preparation. First, its advertisements are accepted by our three leading medical journals, namely, the *British Medical Journal*, the *Lancet*, and THE MEDICAL PRESS AND CIRCULAR. Secondly, its composition is not a secret, its formula being freely published. Under these circumstances, I determined to try the effect of this preparation in a few suitable cases. As a general antiseptic fluid that does not coagulate albumen, and is non-irritant, deodorant and practically non-poisonous, glycothymoline has clearly a wide range of usefulness. My own observations, however, have been practically confined to its use in the nose and mouth, with results that have proved satisfactory in every instance, especially in acute coryza, pharyngitis, influenza, and septic conditions of the mouth.

Case 1.—A. B., male, æt. 37, came to hospital complaining of partial loss of hair of moustache. The patient had been under treatment at various skin hospitals for a chronic eczematous condition of the upper lip and loss of hairs of upper border of moustache. On inquiry, he was found to be subject to frequent "colds in the head." This condition is not uncommon in skin clinics. Suitable ointments and lotions were

ordered for the eczematous condition, and patient was directed to douche the nostrils with a glycothymoline solution, 1 in 3 of water, twice daily. After a few weeks of this treatment the lip showed great improvement, and now is on the high road to recovery, with signs of re-growth of hair.

Case 2.—C. D., acute coryza in a young married woman, somewhat anæmic, otherwise healthy; on the second day of attack, with profuse watery discharge and frontal headache. Coryza cut short and immediate relief of symptoms. Other cases of this kind might be quoted in which acute nasal catarrh was promptly abated and sometimes cured.

Case 3.—E. F., male, æt. 50, chronic nasal catarrh, with deflected septum and frequent blocking of left nostril. During a bout of foggy weather in London the discomfort of the chronic condition was aggravated by acute catarrh, with "sore throat," partial deafness, frontal headache and watery discharge. The use of a spray of glycothymoline, 1 in 3, several times daily, gave great relief, and under this treatment the left nostril was always free. The amount of black matter washed out of the nostrils by the spray bore eloquent testimony to the sootiness of London fogs. (It is unnecessary to quote other cases of chronic nasal catarrh and obstruction benefited in the same way.)

Case 4.—G. H., female, æt. 32, influenza, second day of attack, much prostration, frontal headaches, temperature 102°, profuse nasal discharge, slight sore throat, tongue slightly furred, constipation, complete loss of appetite, pains in the back. This patient was kept in bed and a spray of glycothymoline, 1 in 3, applied frequently to the nose. At the same time a dose of quinine and a purgative, with nutritious food and stimulants, were ordered. The catarrhal symptoms quickly subsided, and the patient recovered more rapidly than in any one of several previous attacks. This result she herself attributed to the nasal spray.

Case 5.—K. L., female, æt. 45. Patient complained of great pain in upper gum, where a swelling had been incised some days previously. The tongue was furred, pus was exuding from the "gumboil," and the breath was offensive. The frequent use of glycothymoline as a wash (warm) afforded immediate relief. The patient was enthusiastic in her praise of the remedy.

Case 6.—M. N., male, æt. 45. Primary epithelioma of soft palate, advanced stage (six months' duration). The tonsils, pharynx and base of tongue had become involved, and the foetid condition of breath and of discharges was most marked when the use of glycothymoline was begun as a spray to the nostrils and to the mouth and pharynx. Under this treatment the parts became clean and sweet, and, to the relief both of patient and attendants, remained so until the end, some six months later. The checking of secondary septic processes in the oro-nasal cavity no doubt lessened the general discomforts of the patient.

Cases 7 and 8.—These were both external wounds seen at hospital. The one was a burn of scalp, and the other a chronic non-specific ulcer of the leg in a middle-aged hard-working woman of poor health, who had borne a large family. In both cases the glycothymoline proved an excellent healing lotion. The ulcer especially, which had been under every conceivable kind of medical

treatment for years, received more benefit from the application (according to the patient's testimony) than from any other single remedy. Owing to conditions of environment and of deficient vitality, the ulcer failed to heal completely.

On this evidence it seems clear that in glycothymoline we have a good and safe application in all septic conditions of the mouth, throat and nose. It seems not improbable that in the near future medical men will attend more than they have done hitherto to the mucous membranes of the upper respiratory tract in influenza, measles, scarlatina, chronic and acute coryza, whooping-cough, and other infectious ailments. Post-nasal catarrh—that curse of modern civilisation—has never been adequately attacked by the general practitioner. Carious teeth, again, another defect of civilisation, are apt to damage the general health considerably. In both these conditions glycothymoline will be found a safe and effective remedy well worth a careful trial in practice.

Vienna Clinical Lectures.

THE CLINICAL VALUE OF RADIOGRAPHY IN TRAUMATIC INTRA-MUSCULAR OSTEOMAS.

By DR. R. KIENBÖCK,

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PART I.

THE following remarks will be directed to an anatomical and clinical description of our present knowledge of traumatic intra-muscular osteomas; particularly their origin, type, localisation, histology, and hypotheses advanced. Twenty cases will be taken from medical literature on the subject, with eight cases investigated by the writer, and his clinical note. The principal part of the subject will be the radiographic anatomy with the changes observed during the first week or month after the injury to the part, and the importance of a negative diagnosis when no shadow of an osteoma is to be observed about the bone. The angle of diagnosis will also be referred to as an important factor in recognition of these neoplasms where the whole circumference of the diaphysis becomes porous and elevated in the neighbourhood of the osteoma, presumably from a separation or detachment of the periosteum. Differential diagnosis is another practical point deserving notice, as it is not always easy to say whether any of these neoplasms are simple intra-tendinous ossifications, progressive myositis ossificans, multiple cartilaginous exostoses, or some other hard accumulations of debris. A fitting conclusion will be the experience of Honzer, Schuler, and Courtin with Holzknicht's theory of fibrous ossification and functional accommodation.

The first step necessary for a clear understanding of intra-muscular osteomas and their pathology will be a brief glance at the anatomy of the part, with the clinical history of the common changes.

Intra-muscular traumatic osteoma may be defined as a bone-like scar in the muscle after an injury of varying intensity, and, properly speaking, may be classified as myositis ossificans. The injuries necessary for its production are often very slight as well as severe. The adductors of the upper part of the leg from riding long is not an uncommon source of origin; the shoulder from long carrying a heavy gun, or the deltoid from strained exercise, as well as severe injury, are all to be traced as the first or starting points of the pathological change, which would not unreasonably point to some other more remote factor in the production of the subsequent phenomena. Be

that as it may, we will not enter on that abstruse phase at present, but confine our attention to those causes that appeal most forcibly to our senses, *vis.*, severe injuries to the part, as first described by Otto in 1816, and thereafter followed by Scherb, 1854, and Rokitsansky in 1856.

It is a curious fact that this disease tends to locate itself about the upper part of the leg and shoulder after severe accidents, such as a kick from a horse, distortion or dislocation of an arm by falls, twists, &c., that frequently are met with in balancers, acrobats, &c., who are putting great strain on these particular muscles by tension or falls in the performance of their various avocations.

Whatever the real cause of the disease, little or no pain attends its course after the accident itself. If the patient be carefully observed, nothing clinically will be found after he has perfectly recovered and resumed his duty. As a general rule, there is no solution of continuity at the seat of injury as far as can be seen by the attendant, although there may be the swelling and discoloration present that usually follow all contusions; even movement in the part may be performed without any evidence of pain or stiffness in the limb. In spite of this apparent happy result of the accident, such as a dislocation of the shoulder, knee, or elbow, a week after a gradual feeling of uneasiness may set in, subsequently followed in the course of a few more weeks by a hardness near the joint. The swelling is usually to be felt lying in the direction of the bone, not regular, but uneven, with round pieces here and there that can be lifted quite up from the bone with the muscle. These neoplasms are not confined to the diaphysis of either the femur or the humerus, but are seen to extend along the muscles on contraction and retraction, as if they were placed in series along the sheaths of the muscles as hard elongated nodules. The period that elapses after the accident before the appearance of these hard concretions is arranged as Münchmeyer has done for operation purposes into three stages, *vis.* :—

(1) Inter- and intra-muscular changes in the fibrous tissue, with swelling in the muscles, accompanied with reactive œdema.

(2) The stage of fibrous tissue induration and shrinking of the neoplastic growth.

(3) The final stage of ossification and union of the isolated parts.

In the greatest number of cases operation is delayed till the third stage has been reached, or till ossification has been clearly demonstrated. In all cases of operation the muscles will be found to have been crushed, the vessels torn, or hæmorrhagic effusion into the affected part has occurred. The local conditions usually indicate a lesion of some kind in the region affected, particularly the soft tissues over the hard diaphysis. In the case of the arm this explanation is conclusive, where a luxation of the forearm at the elbow would throw it back on the humerus, injuring the periosteum, tearing the tendons and muscles by the displacement of the three bones involved in the joint. In the case of the arm the principal muscles injured would be the brachialis internus and biceps, by the enormous distension over the epiphysis of the humerus, while the quadriceps cruris would be similarly affected in the lower extremity. The ossification of the latter has often run its course so rapidly that cases have had to be operated on within a week of the lesion where true bone has been present. In some cases this hardness varies from hard bands of cartilage to genuine bone itself; indeed, all three forms may be present, as bone in thin plates covered with cartilage and hard tissue, which may form the separating line between the true tissue and neoplasm, where cysts and fluids often form to add to the enlargement.

We now come to the more speculative part of the subject—the origin of bone formation. Is the product inflammatory?

Wide differences of opinion have raged round this point of inflammatory or simple growth. In some

of the cases coming under my own observation the latter has prevailed, commencing in the intra-muscular fibrous tissue and gradually affecting the torn fibres in the muscle.

Another advocates the metaplastic theory that the muscular fibre itself is converted into fibrous tissue first, then cartilage, and finally bone. The greatest number of authors now concur in Virchow's opinion that the osteoma is intra-muscular and inflammatory in origin, although he was inclined to believe in an ossifying diathesis, as many cases occur where greater destruction of muscle takes place with no subsequent ossification. Possibly the peculiarity of the injury to the muscle itself may be the immediate cause.

There is yet another point that has been widely discussed, whether the fibrous tissue that forms along the muscle is a projection of the periosteum from the bone, or is it a genuine outcome of the fasciculi of the muscle, or from the fibre of the muscle itself? Whatever may be the true history of the case, it is found that the greatest number of cases have their origin in connection with the periosteum of the diaphysis of the bone, and the lesion is never far removed from this source, which conveys the general conviction that all presumptive, isolated osteomas are only prolongations of periosteum in some form, as fine pedicles have been traced in many secondary osteomas of this character. The rapid formation of a hard, resistant substance shortly after does not militate against this theory, as Borchard relates a case of a groom who received a kick from a horse on the side of the face, whereby the masseter muscle became ossified within twenty-one days after the accident, and whose origin was traced to the periosteum. Many eminent investigators, however, have traced no connection, and firmly believe in a primary intra-muscular osteoma. It may even be osteophytic in origin, and by some proximate change in the fibrous tissue become transformed into an ossified growth. In this connection it might be well to quote Holzkecht's experience, which he gave to the profession a year ago:—"In some of these cases local irritation of the periosteum will be met with, where a sort of ossified callus will be found. But there are other cases where the fibrous tissue becomes ossified without any apparent connection with the periosteum, spreading deep into the muscular tissue or inserting itself between the fibrous bundles of the muscular fasciculi. These insertions form exostoses, whose processes may again be traced to the periosteum, and thus circuitously back to the periosteum. We may therefore conclude that there is some common pathology in all these extra-ossæous formations, although the cause and effect are not easy of demonstration." The results of radiography are in favour of an "intra-muscular, traumatic osteoma," but, unhappily for this hypothesis, no traumatic conditions can be discovered in many of the cases investigated.

A short *résumé* of some of the cases met with in literature may assist us in forming a judgment on the subject.

Bremig reports a lady, *æt.* 19, having received a kick from a horse on the hip, which seven weeks later became hard and resisting. After examination with the Röntgen rays, it was resolved to remove the osteoma. The femur was in no way changed.

Courtin showed a radiogram recently of a boy, *æt.* 11, who had luxation of the left elbow-joint, followed six weeks after with an osteoma of the brachialis. This appeared to be connected with the epiphysis in origin, though actually in the muscle.

Rothschild records one in the right brachialis muscle of a young man, *æt.* 38, a few months after hard driving. The radiogram shows the bony structure rising from the lower part of the humerus in the fasciculi of the internal brachialis, and winding round the tendons as well as the muscle.

Köhler shows another of the elbow in a patient, *æt.* 47, where the brachialis internus muscle is involved and again traced to the diaphysis. This osteoma

appeared about five years after the supposed injury. There seems to have been some pain in movement in this case, with a well-defined tumour.

The same author records a case in the lower third of the femur, occurring in a boy, *æt.* 16. On the anterior side of the femur, about 8 centimetres above the patella, a hard tumour was present. No particular time could be assigned to the accident, but it is supposed to have occurred in childhood. The osteoma resembled a cabbage, and was connected with the diaphysis by a long pedicle.

Rammstedt gives the history of an officer, *æt.* 23, who received a kick from his horse on the hip, and two months later a hard, resistant tumour formed in the injured region. With the rays was observed a shadow 15 centimetres long and about 6 or 7 centimetres from the lower end of the femur, apparently situated in *mus. vastus internus*. The movements of the knee were so limited that an operation was necessary.

The same author gives the Röntgenograms of a groom, *æt.* 18, who had a kick on the middle third of the femur of the left leg, which showed no connection with the diaphysis, although the periosteum was found on operation to be much swollen and elevated with osteophytes. The microscope proved the tumour to be composed of fibrous tissue, cartilage, and bone.

Grünbaum showed radiograms to the *Gesellschaft der Aerzte* of a labourer, *æt.* 54, who sustained a severe blow from a falling plank on the femur. It was followed by pain, swelling, and discoloration of the skin, which a month later became hard and immobile, with stiffness of the knee. The radiogram showed a long, dark mass along a great length of the femur.

Berndt gives radiograms of two cases, *æt.* 10 and 21 respectively, who suffered from kicks. In both cases the shadows obtained are in front of healthy femurs. Both were operated on, and when closely examined were found to have originated in the periosteum. The microscope confirmed the opinion that the neoplasm was derived from fibrous, cartilaginous, and osseous tissue. This led Berndt to conclude that the periosteum was the proximate source of all these osseous formations in muscles, while Bremig and Rothschild as confidently affirm that the diaphysis is the genetic source of the neoplasm, as they always find a clear zone in the radiogram between the tumour and diaphysis, which would not be if it were connected with the periosteum. Berndt further asserts that he traced the pedicle to the spongiose portion of the bone.

The same author records a third case, where the traumatic centre was in the quadriceps, but strange to say no shadow could be observed by the Röntgen rays. The operation proved the neoplasm to be a bony structure of the spongiose class.

Overman has collected 55 records of this disease, of which 11 are not proved to be genuine traumatic cases. Two of the cases seem to be exostoses. He relates one of his own, a Hussar who received a kick from his horse. Nine months after a hard tumour, palpable and visible by the Röntgen rays, resembling bone, appeared. There were also dark shadows lying along the femur, betraying some relationship. By the operation three hard bodies were extracted from the *vastus externus*, bound up with fibrous and membranous tissue.

Schulze found, in a case of a kick from a horse on the upper part of the femur, a hard, resistant tumour which left the contour of the femur unchanged in the radiogram, but the operation revealed an osseous cyst in communication with the periosteum, where the femur seemed to have been in contact.

Schuler tells how pressure on the femur produced a hard swelling in two cases, which remained unchanged for 1½ and 2½ years respectively. The Röntgen rays showed a distinct stalactite connection with the femur.

Another case, of a man, *æt.* 22, who, after a fall on ice,

had a hard swelling, 2½ months after which the radiogram showed two hard growths lying parallel with the femur, with two fine connections to the periosteum. Later the hard tumour was removed, but unexpectedly recurred.

He also relates the case of a student, æt. 20, who had received an injury to the deltoid, after which a hard tumour appeared over the insertion of the *atissimus dorsi* and *teres major* into the humerus.

Schuler remarked that he had seen many different forms, some connected with the periosteum, others were not.

Depages gives the radiogram of a colleague, æt. 30, who, after a fall on the arm, had a swelling about the size of a walnut over the elbow two months after, which interfered with the movement of the elbow, and for which it was extirpated.

A second case was five months after the trauma on the deltoid. The rays showed its connection with the glenoid cavity.

Zimmermann records under "Myositis Ossificans Traumatica," a young man, æt. 24, who had received an injury in the *brachialis internus*, after which an osseous swelling occurred, and was removed. The rays previously showed its connection with the humerus.

Hannecast relates the history of several traumatic osteomas, among which is a wound cutting the soft tissue of the thumb, fourteen days after which an elongated osteoma appeared in the muscles of the thumb.

In another of the elbow from contusion, the same results occurred, with immobility of the elbow-joint.

Farganel tells how a soldier in turning a *soubresant* had a sprain at the thigh in the right leg. After two weeks a slight swelling commenced, spindle-shaped and bony hard. The rays added nothing to the diagnosis. As the leg became very limited in movement it had to be operated on, which revealed an osteoma 14 centimetres long and 1·8 broad. Recovery was complete.

Having reviewed the experience of other observers, I shall now venture to place eight of my own cases before you.

Case I.—A female, æt. 33, came to me in 1898 to be examined by the rays. Six weeks prior to this she had a dislocation of the left elbow-joint which was immediately after reduced. Gradually after this time a tumour was observed to form above the joint, which interfered with its movement, as there

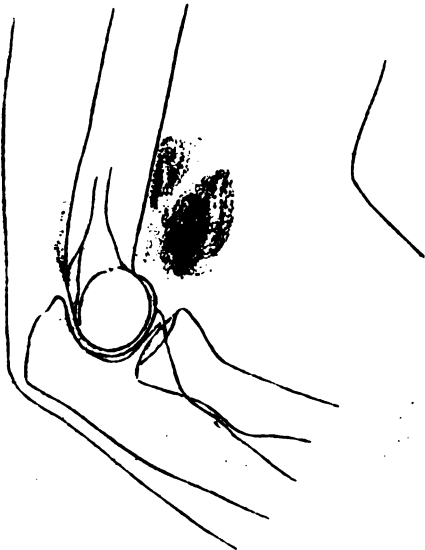


FIG. 1.

CASE I.—Left Elbow, Medical Section. Half the natural size.

was slight pain on pressure. The radiogram, as shown in the accompanying diagram (Fig. 1), revealed a hard, bony structure at the lower front part of the humerus, which was separated by a clear zone

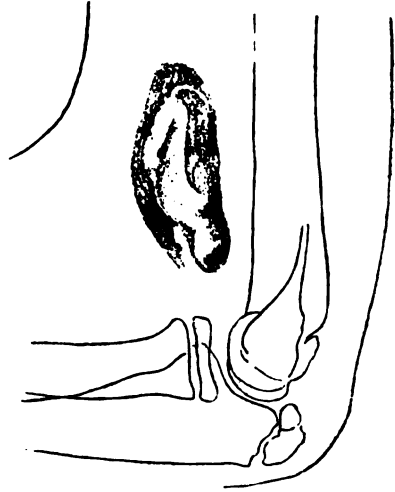


FIG. 2.

CASE III.—Right Elbow. Medical Section. Half natural size; 12 years old, with open epiphyseal union.

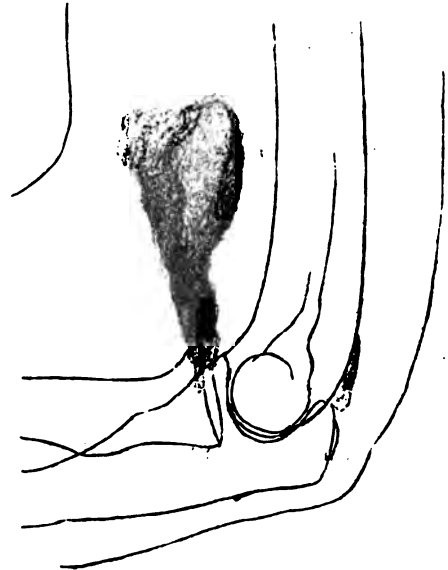


FIG. 3.

CASE IV.—Right Elbow. Medical Picture. Half natural size.

from another swelling or shadow higher up the bone and deeper in the limb. Both shadows were very dark, with apparent bands of connection. Posteriorly a dark band was observed to pass downwards closer to the humerus behind, extending in to the joint with a clear zone like the others, uniting it with the diaphysis of the long bone. No trace of any lesion could be observed in humerus, radius or ulna. In this case mechanical treatment was persevered in, and no operation performed, as the patient objected. Strange to say, this treatment had the effect of checking any further growth. It is now five years since the accident, and at the present time very little swelling can be seen with fairly good movement, which gives him a feeling of tearing the sinews of his arm when in motion. The osteoma may be said to be at a standstill in this case.

Case II is a man, æt. 31, who three and a half months before examination had fallen on his right

elbow, which was immediately followed by pain and swelling of the joint, with a good deal of discoloration, and inability to bend the limb. The swelling at the time of examination was smooth, hard, immovable, and about the size of a large nut, that prevented the complete flexing of the arm. The Röntgen rays gave a shadow 2 centimetres long and 1 broad immediately in front of the distal end of the humerus, with a delicate white band, 6 mm. wide, running into the union of the epiphysis at right angles to the humerus. The skeleton was quite normal, except this attachment. The treatment adopted was massage and passive movement.

Case III is a strong, healthy-looking boy, æt. 12, who eight weeks before skiagraphing had an awkward fall on his right arm while at his gymnastic exercise, which caused the elbow to swell and become discoloured, with great tenderness on pressure. With suffusions the swelling soon disappeared, but the power of extension and flexion was greatly impaired by a round hard tumour immediately above the elbow-joint, movable from side to side, and smooth on the surface. The radiogram is given in Fig. 2, lying as an oval swelling in front of the elbow-joint, while the radius, ulna, and humerus are quite normal, with no apparent direct connection between the tumour and epiphysis. It measured 4·8 centimetres long and 2·1 broad. The neoplasm was not homogeneous, but appeared to be composed of irregular bands, thus making the surface uneven.

In this case an operation was performed, and the osteoma extirpated from the brachialis muscle. No bands could be traced to the humerus or coronoideus ulnæ. The histological composition of the neoplasm was cartilage, fibrous tissue, and layers of bony structure.

(To be concluded in our next issue.)

Lunacy Department.

ASYLUM REPORTS.

Argyle and Bute District Asylum, Lochgilphead.—The number of patients admitted to this asylum during the year was 73, as compared with 67 in the preceding year; 34 were men and 39 women. The average age of the patients admitted was 48 years; 34 suffered from some form of bodily disease, and 18 of the remainder were in impaired general health. It is very interesting to note in the report of this asylum that no case of general paralysis of the insane has been admitted during the last three years, and the last general paralytic in the house died a few months ago. The recovery-rate was 31·5; nineteen of the cases which recovered had been under treatment for less than one year, and one patient recovered after upwards of twenty years' residence. Dr. Cameron states that eleven patients were received in such an enfeebled state of health that they died within periods varying from a few hours to thirty-three days after admission; the average duration of residence of these cases was only thirteen days. This practice of sending patients in a moribund condition to asylums is becoming much too common, and some drastic measure ought to be taken to remedy this. Doubtless in such cases the medical man who is called into certify a patient insane, and also certifies the patient to be in a sufficiently good state of bodily health to be removed to an asylum, is much to blame. In many such cases we see at once on admission that they are suffering from nothing short of the delirium of death; this reflects gravely on the medical man who signs such certificates. The Commissioners in their report speak well of the management and care taken of the patients in this asylum.

Govan District Asylum, Hawkhead.—The total number of patients under care and treatment during the year in this asylum was 750. The average daily number resident was 480; the recovery-rate was 43·8 on admissions, and the deaths numbered 66. Dr. Watson, in his report, discusses very fully the causes assigned in the various cases of insanity and the defects of this method of investigation. He states that the chief fallacies are of two kinds: those affecting the observer, and those affecting the field of observation. After pointing out how absolutely worthless the information obtained from the patient's relatives often is, he states that the investigator himself must be a psychologist in more than name; without a keen and penetrating eye for character he will be unable to estimate the value of evidence, to discriminate between what is actually true and what his informant merely believes; but all his psychology and patience will be thrown away unless he chances to possess the rare gift of the scientific spirit. Men of this stamp, he says, are hard to find, and, without disrespect to an estimable body of men, one may doubt if many medical officers of asylums even approach the standard. The whole of Dr. Watson's report affords much profitable and interesting reading. The Commissioners, in their report, strongly recommend the introduction of electric lighting because of the dinginess of the walls caused by the unprotected gas-burners. Enlargement of the pathological department is being carried out; three rooms for pathological, chemical and bacteriological research respectively are being added. In the case of injuries inflicted by a male attendant on a patient the matter was reported to the Procurator-Fiscal. The attendant was tried and found guilty, and fined £5 or twenty-one days' imprisonment. Such incidents, we are glad to say, occur seldom in this our day, and are most unpleasant to all concerned in the treatment of the insane. Yet, good may result by showing to the public, who still tend to be suspicious of the treatment that goes on within asylum walls, how seriously such offences are now viewed by those in authority. The general condition in which the patients were found is reported on most favourably by the Commissioners.

Kirkland's Asylum, Bothwell.—Dr. Skeen, in his report, states that the total number of patients under treatment during the year was 286, with an average number in residence of 215. The recoveries show a percentage of 33. The cases admitted, primarily due to the action of alcohol, number 8—not a large proportion; while its action, combined with other causes, can be traced in 4 other cases—a total of 12 or 15 per cent. of the total admissions. This, in the light of other statements on the subject, may appear very small, but we agree with Dr. Skeen in thinking that much exaggeration has of late been indulged in with reference to this matter. The married men's houses, the single men's home, and the nurses' home are now in occupation. In the single men's home there is accommodation for eight single men and a house for the head male attendant, who supervises them. It is well and comfortably furnished, while the isolation from the asylum, with the quietness and privacy they obtain, is fully appreciated by its occupants. The behaviour of the men lodged there is in every way as good as when lodged in the asylum. This, we learn, is the first home of such a kind built in

connection with any asylum in Scotland, and it is gratifying to learn that it works so successfully. The Commissioners, in their report, recommend the acquiring of more land for this asylum, as the asylum buildings are outgrowing the small amount of land in connection with the Institution, and there is no site for such necessary additions as future requirements are certain to demand. This report contains much that is interesting and readable.

The Out-Patient Departments.

WEST LONDON HOSPITAL.

Dermatological Cases under the care of
DR. P. S. ABRAHAM.

[Reported by DR. G. N. MEACHEN.]

CASE I.—**SCLERODERMIA WITH BULLÆ AND ULCERATION.**—A widow, æt. 58, came on July 30th, 1904, with a sore place on her left leg. According to her account, the limb had been somewhat white and shiny for the last twelve months, but three months ago she first noticed some little, dry, raised patches which turned to small blisters upon the front of the shin. The other leg was affected to a lesser extent, but both ached very much when kept for long in a vertical position. Soon afterwards two large blisters appeared which "ran together," subsequently breaking and leaving a sore place of which she then complained. She had had three children, the youngest being twenty years old, and no miscarriages.

On examination, there were three large bullæ situated upon the front of the left leg, about the size of a small hen's egg, and filled with a brownish-looking fluid. Above and external to the largest bullæ was an irregularly shaped ulcer, with an indolent-looking base. The margins of the ulcer and the integument over the front of the upper part of the tibia as far as the tubercle was shiny, and presented the characteristic "hidebound" appearance and feel of sclerodermia. There were some minute varicosities just below the knee. The condition in the opposite leg was sclerodermatous, but there was no ulceration.

Dr. Abraham remarked that the presence of bullæ and ulceration upon a sclerodermatous area was exceedingly rare, and only a few cases had ever been seen. The more usual complication was that of atrophy, in which the affected areas presented a sunken appearance. Some pigmentation was generally observed in connection with sclerodermia, though it was not a specially marked feature of this case. A mild antiseptic lotion and ointment were prescribed, and rest in the horizontal position was enjoined as far as possible. When the bullæ had shrivelled and the ulcer showed signs of healing, the affected area was exposed to the X-rays, which proved most beneficial. (The case was afterwards shown before the West London Medico-Chirurgical Society.)

CASE II.—**BILATERAL HERPES ZOSTER.**—The patient was a boy, æt. 14, who was first seen on December 2nd, 1904. Five days previously an eruption of small blisters had appeared upon his face, preceded by some neuralgia. His general health had been affected to a slight extent, and the tongue was furred.

On examination, typical patches of herpes were seen covering the submaxillary, submental, labial, and malar regions upon both sides. The auricles were red, and a few herpetic vesicles were seen along the margins of the right pinna and tragus. The inter-orbital region also showed a small patch. The temperature was 100.2. There was a slight enlargement of the lymphatic glands beneath the chin.

It was remarked that exceptions to the unilateral distribution of herpes zoster were distinctly rare, and such had been observed by Elliott, Finny, Colcott, Fox, and others. The level of the eruption upon both sides was not always the same, this being specially the case in zoster of the chest or abdomen. The peculiarity of this case was its abundant distribution upon

corresponding parts of the two sides of the face. The parts about the ears showed quite an inflammatory reaction. No lesions were seen upon the buccal mucous membrane, though these were commonly observed in cases of severe facial herpes.

The boy was given a simple ointment with which to smear the areas and protect them from friction, and a quinine mixture to be taken three times a day.

Transactions of Societies.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.
CLINICAL MEETING HELD DECEMBER 21ST, 1904.

DR. J. O. AFFLECK, Vice-President, in the Chair.

PROFESSOR SCHAFER demonstrated his method of artificial respiration, of which extreme simplicity was an important feature. The patient is placed in the prone position, and the operator kneels by his side facing in the direction of the patient's head, and in such a position that his hands rest on the lower part of each side of the thorax. By allowing the weight of his body to fall on his arms the operator thus compresses the thorax and squeezes air out; by raising the body the thorax is allowed to expand and air enters. It was quite easy for one man to keep up artificial respiration for an hour in this way, which was not the case in Sylvester's method. The advantages of the prone position were that the tongue did not fall back, and that water, mucus, &c., escaped readily from the mouth, that more air was driven from and entered the thorax at each stroke than in Howard's method, and that there was not the same liability to fracture of ribs and injury to the liver as in Howard's method.

Dr. W. ALLAN JAMIESON exhibited a case of Extensive Tertiary Serpiginous Eruption, showing the advantage of combining local and constitutional treatment. After disappearing on the administration of iodide the eruption had recurred within two months of the cessation of the drug. It had then been scraped, in addition to being treated with iodide, and the cure had been much more permanent. (2) A case of Lichen Planus which was fading, and showed a peculiar brownish coloration.

Dr. NORMAN WALKER showed (1) two cases of Keloid situated in the typical position over the manubrium sterni. Under treatment by the X-rays considerable amelioration had taken place, the pain in particular having been much diminished. (2) Two cured cases of Lupus, one of which had had no treatment for eighteen months. In both cases the X-rays had been used, and the results had been, so far, permanently good.

Dr. DAWSON TURNER showed (1) a case of Tic Doloureux of one month's duration, for which various remedies, including extraction of all the teeth, had been fruitlessly tried, cured by the use of the static breeze. (2) A case of Epithelioma of the Lip of two years' duration, treated by radium and X-rays. (3) Two cases of Non-healing Ulcer healed by X-rays; and (4) Injury to the foot healed by sinusoidal currents.

Mr. HODSON showed a child, æt. 3, after primary disarticulation at the hip-joint for injury. Attention was drawn to the immense value of intravenous injection of saline and adrenalin in warding off shock in such cases.

Mr. C. W. CATHCART showed (1) a patient who had suffered for nine months from Pott's Disease and Pressure Paraplegia. He also had a tuberculous testicle. Laminectomy at the level of the tenth and eleventh dorsal spines showed that the cord was compressed anteriorly. After the operation the patient rapidly improved, and could (in nine months' time) walk quite well in a go-cart. (2) A patient who some months ago had come complaining of a painful swelling in the back of the neck, which ultimately resolved itself into an abscess, and was opened. The patient

was then lost sight of, and when seen again was found to have paralysis of his arms and legs, the paralysis having begun very soon after the incision of the abscess. Removal of a lamina and scraping away of a mass of granulation tissue in the spinal canal was followed by complete recovery. (3) A patient after incision of the kidney for Septic Nephritis and Pyelitis. The temperature had fallen, and there was great general improvement.

Dr. MACKENZIE JOHNSTON showed a patient after Extradural Abscess following mastoid disease. There was also sinus thrombosis, and the noteworthy point was that the girl, though the condition had been going on for a week or longer, walked up to hospital without much sign of discomfort or appearance of illness.

Mr. F. M. CAIRD showed (1) a patient after operation for Contracture of the Muscles of the Forearm. After an injury of doubtful nature to the elbow-joint, which had been healed by bandaging in a rectangular splint, wrist-drop had developed. When Mr. Caird first saw the case it closely resembled the appearance of musculo-spinal paralysis, and in fact there was a scar of a previous operation for stretching the musculo-spinal nerve. The wrist-drop, however, was due to contracture, not to paralysis, and the case was an example of what was called "ischemic paralysis" or "contracture": it was caused by pressure of bandages and occurred mostly in young subjects. The treatment was to split and suture the tendons. (2) A second case of the same condition, treated by splitting and suture of the lengthened flexor tendons, in which a secondary contracture of the extensor muscles had occurred. (3) A patient after extirpation of the rectum and anus for a cancer of four years' duration by the combined abdominal and perineal route. (4) A patient after suture of two successive perforating gastric ulcers. There was a rather prolonged history of gastric disturbance. At the second operation the stomach was found to have an hour-glass constriction resulting from the suture of the first ulcer, so a gastro-entostomy was performed at the same time.

Mr. ALEXIS THOMSON showed a case of gout, from which very large tophaceous concretions had, from time to time, been removed.

Mr. COTTERILL showed specimens of (1) ileo-cæcal intussusception; (2) hydronephrosis; (3) loose bodies from the knee-joint; and (4) cancer of stomach; and Mr. CAIRD (1) rectum removed from patient referred to above; (2) tuberculous kidney, with drawings illustrating the results gained by Luy's separator; and (3) preparation of stomach, showing posterior gastro-jejuno-stomy and lateral anastomosis.

THE OTOLOGICAL SOCIETY OF THE UNITED KINGDOM.

ANNUAL MEETING HELD DECEMBER 5TH, 1904.

The President, DR. THOMAS BARR, in the Chair.

AFTER the election of Officers and Members of Council for the ensuing Session, 1904-05, a list of whom will be found in our "Medical News" column, the meeting resolved itself into the usual ordinary meeting, under the same presidency.

INFLUENZAL LEPTO-MENINGITIS.

Mr. A. E. CUMBERBATCH read notes of a case of fatal lepto-meningitis following upon acute suppurative otitis media of influenzal origin. The antrum, sulcus lateralis, and the upper surface of the tegmen tympani were explored by the usual radical operation. A small quantity of pus was found in the antrum, but none in the other places mentioned. No symptoms of any kind, except a rise of temperature to 106° F., followed the operation. At the *post-mortem* examination, purulent lepto-meningitis was found; but no direct communication between the meningeal lesion and the middle ear could be discovered. Mr. Cumberbatch suggested that it would be well in all acute cases, where exploration of the mastoid failed to give relief, to explore the sulcus lateralis and the middle fossa of the skull. He also asked whether anything further could be done, and for

the experience of members in the use of antistreptococcal serum injections of 10 c.c. every hour.

The PRESIDENT and Dr. URBAN PRITCHARD considered the prognosis of lepto-meningitis in influenza to be absolutely bad.

Mr. ARTHUR CHEATLE thought there ought to be no question of further exploration when the mastoid operation failed to give relief.

Dr. MILLIGAN thought draining the subarachnoid space afforded a chance of relief.

Mr. C. A. BALLANCE distinguished between two forms of lepto-meningitis—one, where the pus lay between the dura and pia mater, and was fairly limited, in which operation gave a good chance of success, and another, where the pus lay between the pia and brain, and followed the prolongation of the pia into the fissures and sulci of the brain, in which it was quite impossible to drain away the pus. Mr. Ballance further reminded members that meningitis might occur in influenza independently of any middle ear suppuration.

Dr. DUNDAS GRANT referred to the recent paper of Lermoyez, in which he advocated repeated lumbar puncture in the treatment of otitic meningitis.

Mr. HUGH E. JONES related two cases operated on by him in which he found the second form of lepto-meningitis described by Mr. Ballance, and in which extensive removal of bone and multiple punctures of the pia arachnoid failed to drain away the semi-solid pus present.

GENERALISED TINNITUS.

Dr. FURNISS POTTER reported a case of severe tinnitus, with almost complete loss of hearing, in a male, æt. 21. Drug treatment had proved valueless. Dr. Potter asked whether, in the opinion of members, this was a suitable case for removal of the cochlea or division of the auditory nerve.

This interesting question was discussed by the President and a large number of members, who were unanimously opposed to operation, because in this case the tinnitus, instead of being referred to one or both ears, was generalised over the whole head, and was therefore in all probability of cerebral origin. Dr. Potter concurred in this opinion.

DEAFNESS WITH NUMBNESS OF THE EAR.

Mr. ARTHUR CHEATLE read notes of a case of internal ear deafness of sudden onset and associated with a "dead feeling" in the ear of a woman of middle age. Mr. Cheatle attributed the numbness to an associated affection of the second and third cervical nerves. "Noises," lasting twenty or thirty minutes and followed by deafness, had come on after the patient had yawned seven or eight times. There had been no vertigo, the deafness persisted, but the tinnitus had become "occasional." Examination of the ear revealed nothing but marked nerve deafness.

ACUTE OTITIC CEREBRAL ABSCESS.

Mr. A. L. WHITEHEAD reported the case of a boy, æt. 14, who, having had double otorrhœa for twelve months was suddenly attacked by acute headache. When first seen headache had lasted twenty-four hours, drowsiness six hours, coma three hours. Both middle ears were filled with pus and granulations; both mastoids were tender. The radical operation was performed on both sides, and subsequently exploration of both temporo-sphenoid lobes, the latter with a negative result. The coma continued; thirty-six hours later an abscess in the right temporo-sphenoid lobe of the brain was found and drained. The patient recovered. Mr. Whitehead remarked on the comparative rarity of acute abscesses, and the difficulty of diagnosis and comparative frequency of acute extension of chronic abscesses.

A MODIFICATION OF THE RADICAL MASTOID OPERATION.

Mr. CHARLES HEATH read a short paper (founded upon an experience of 400 operations) on the restoration of hearing after removal of drum and ossicles by his modification of the radical mastoid operation for suppurative ear diseases.

The discussion on Mr. Heath's paper was deferred until the next meeting.

EXHIBITS.

Dr. ALBERT GRAY gave a lantern demonstration of the following specimens:—The human membranous labyrinth, showing (a) an accessory ampulla in the horizontal canal; (b) supernumerary otoliths or calcareous deposits in the labyrinth. The membranous labyrinth of the seal, showing (a) the large size of the organ; (b) the large otoliths. A section of the cochlea of the mouse. A section of the organ of Corti of the mole, showing the spiral arrangement of the nerve-termination at the base of the hair-cells. Section of the cochlea of the guinea-pig.

Mr. RICHARD LAKE exhibited an oto-masseur driven by a turbine (Ash) giving 2,000 strokes per minute.

In the evening the Annual Dinner, at which the President, Dr. Barr, presided, was held at the Trocadero Restaurant.

The principal guests were Sir Thomas Barlow, Sir Douglas Powell, Sir Felix Semon, Dr. Fredk. Roberts and Dr. Nestor Tirard.

In responding to the toast of the Otological Society, the President set a high ideal before the members; he hoped some day to see in working order a scheme of research in the pathology of ear disease, and to see established a central museum of otology to which all students would have access.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, January 1st, 1905.

CHRONIC APPENDICITIS.

THERE is a tendency to-day to consider appendicitis no longer as an acute malady commencing suddenly, but as a process essentially chronic, subject to acute symptoms of which the clinical expression is the "attack." It is in attentively examining the history of the patients that digestive troubles and pain can be discovered, which constitute the true prodroma of the appendicular attack.

Three orders of symptoms, says Dr. Wagon, exist in chronic appendicitis: pain, dyspeptic troubles, and certain phenomena resulting from chronic infection. The pain can be spontaneous or provoked, but rarely absent. In children it is seated in the umbilical region or on the right side of the umbilicus. It appears suddenly without prodroma while playing, or is provoked by some movement; the child stops, turns pale, and puts his hand on the painful spot. The pain only lasts a few seconds, and disappears without leaving any local tenderness. In the adult the seat of the pain varies, and is of little importance as a diagnostic. Sometimes dull, it presents a greater intensity on the right side. It can be found in the epigastric region, the lumbo-iliac region, in the left iliac fossa, and at the base of Scarpa's triangle. The pain, however, is never so intense as to make the patient cry out. Pain provoked by a gentle and deep pressure over the point of MacBurney is the most important and the most constant symptom; but, contrary to the received opinion, its absence at this point does not necessarily imply the absence of the appendicitis.

The digestive troubles are extremely variable. The most alarming are the acute phenomena of intestinal infection, with high fever, foetid diarrhoea, vomiting (sometimes), loaded tongue, foetid breath, which appears so frequently in the course of chronic appendicitis, particularly in children.

A very important phenomenon which is sufficient to give the idea of appendicitis, particularly in the adult, is that such patients digest certain foods with difficulty, always the same for each patient (meat, sauces, fatty foods); and the patients have remarked that the digestion of these foods always coincided with a return of the painful abdominal sensations. In certain cases vomiting is observed after meals—children especially suffer from this kind of dyspepsia. Constipation is very frequently observed. Patients suffering from chronic appendicitis frequently present

a facies characterised by anxious expression, sub-icteric tint, sunken eyes, pinched nose—phenomena depending on a certain state of congestion of the liver. The most frequent complication, as well as the most important, of chronic appendicitis is the acute attack.

As to the treatment of chronic appendicitis, it mainly consists in rest, régime, and a judicious employment of purgatives.

INCONTINENCE OF URINE IN CHILDREN.

Incontinence of urine is observed almost always in children from three to ten years old; some have it diurnally as well as nocturnally, but others, and they are the most numerous, urinate simply at night. According to M. Guinon, these children belong to the degenerate and neuropathic type. It can be said that the commencement of this neurosis is the hyphen between first and second childhood; it is the persistence of the habits of infancy, and results from derangement of the nerve centres. The trouble manifests itself by atony of the sphincter added to the spasmodic contraction of the muscle of the bladder, a veritable spasm, independent of the will. If such is the affection, an antagonist should be opposed; an anti-spasmodic must be chosen, and atropine is indicated in preference to belladonna, which is much less active, or to rhus aromanticus, which does not always succeed.

M. Guinon employs the following solution:—

Sulphate of atropine, 1 centigramme;
Water, 10 grammes.

For a child, *æt.* 6, five drops are given three times a day in a tablespoonful of sweetened water, and increased by one drop each time until 10 drops are reached, or 30 drops daily. This latter dose is maintained for two or three days to insure a complete cure.

In cases of very young children (two or three years) the initial dose is 2 drops three times a day, and increased in the same manner until 15 drops in the day are attained. As an adjuvant to the above treatment, which seldom fails, the wet sheet may be employed morning and evening for half an hour.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, December 31st, 1904.

At the Society for innere Medizin, Hr. Plehn spoke on

PSEUDO-LEUCÆMIA.

He said two distinct diseases were designated by this name, one with multiple tumours, in which peculiar polymorphous wandering cells participated. This disease had certainly nothing to do with true leucæmia. Then true lymphadenomata of homogeneous cells, the carriers of these tumours, and in the blood not the characteristic features of leucæmia, because a flooding of these blood cells had not yet taken place—a latent leucæmia. Under certain circumstances this feature remains limited to the bone marrow, and then occasionally the leucæmia remains latent until death. Then the disease was looked upon as pernicious anæmia, according to the behaviour of the blood. Sometimes, however, the leucæmia became manifest from the character of the blood in a few days, as Litten first pointed out. Benda also had occasionally found a symptom of pernicious anæmia in bone marrow. There were therefore many connecting links between leucæmia and pernicious anæmia. The speaker, in the case of leucæmia, had found the same iron reaction that was met with in pernicious anæmia. He then shortly sketched the clinical history of a case from which microscopic sections (shown) were taken. A patient, a middle-aged man, who had been ailing for months, attended Litten's polyclinic on September 5th, when the disease was diagnosed as lymphatic leucæmia. The proportion of red corpuscles to white was 1:12½; a week later the proportion was 1:350; some days later the changes of pernicious anæmia were found in the peripheral blood. Four weeks later the patient,

who had taken to bed, was admitted into the speaker's ward. Examination of the blood showed 9,375 white against 160,000 red blood corpuscles. The patient improved, the swelling of the spleen receded (perhaps from large doses of quinine), and in a week the red blood corpuscles had increased to a million. Then occurred rapid disappearance of red corpuscles, great increase of lymphocytosis (65,000, then hæmorrhage) and the patient died with symptoms of sepsis. There were streptococci in the blood.

Dr. Benda remarked that the symptoms had been very unusual. The large lymph gland tumours were absent, and the spleen had been much larger than was usual. The bone marrow showed an almost complete lymphoid change. Metastatic lymphomata were found in large numbers, especially in the liver and kidneys; the latter were swollen and so much filled with lymphomata that they looked almost white. There were numerous growths of lymphomata on the walls of the veins.

In the *Zeitsch f. N. Med.*, Dr. Metzger related a case of

MENSTRUAL JAUNDICE.

The patient was a healthy woman, æt. 45, therefore in the climacteric period, who shortly before commencement of a period or during it, regularly became jaundiced.

As regarded the connection between the menstrual process and the onset of jaundice, it was to be borne in mind that latent gall-stone trouble would react with an attack during menstruation, but in the case under notice there was no trace of gall-stone mischief. Senator, in explanation of his cases, had assumed a hyperæmia of the liver causing pressure on the bile-passages, and consequent stasis of bile. E. Pick thought it was a functional disturbance of the liver cells. The writer concludes that in his case the jaundice was caused by reflex contraction of the bile-passages.

DISCUSSION ON PHYSIOLOGICAL ALBUMINURIA.

In the discussion that followed Senator's address on the subject, Hr. Max Salomon said the subject had to be treated clinically, as to its diagnosis, its prognosis, and treatment. He could not agree with the view that when albuminuria appeared under certain conditions—after a hearty meal, fatiguing marches, cold bathing, &c.—it was of no pathological importance. He saw in it in any case a warning sign, and it behoved such patients as possessed it to avoid anything that could bring it on. It was plain that with them the kidneys were the seats of lesser resistance. He would not deny that such a condition could be recovered from, but at the time one could form no judgment as to whether they would recover or end in chronic nephritis. A case came to his own knowledge, in which a young medical man found occasional albumin in his urine, and consulting a medical friend was told that it was physiological. Much comforted, he went on as before. Some years later he thought of marrying, and not wishing to marry as an invalid, he consulted another physician, who also told him the albumin was physiological and harmless, and that he might marry with an easy mind. The gentleman did marry, and four or five years afterwards died of contracted kidney, leaving a wife and two children in straitened circumstances. The case spoke volumes. It taught us that albuminuria was not to be treated as a *quantité negligible*, but seriously, and it taught us that there was no such thing as a physiological albuminuria, but that every albuminuria was pathological.

Hr. Fürbringer had seen cases of complete recovery, one that of a medical man who had undergone severe and sudden shock, and whose urine contained 6 per cent. of albumin. Complete recovery took place within eight months.

Hr. L. Caspar had watched three cases for years, and in the end they all turned to chronic nephritis.

Hr. Benjamin had seen albumin in the urine of a girl two days before each period, and Klemperer had seen such cases.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, December 31st, 1904.

HARD TRAUMATIC ŒDEMA.

RUDOLF showed a case of hard traumatic œdema to the members of the Gesellschaft of some interest to practitioners. The patient got his left arm hurt, which swelled up, but after effusion it soon healed again. Fourteen days later he got the same arm injured again, which swelled, with pain, but did not go down as before. The skin is now red and thick all over the back of the hand and fingers, which prevents flexing of the fingers and hand, except with great pain. There is no fever, nor can any fracture or injury to bones be observed by the assistance of the Röntgen rays, neither can atrophy of the bone be discerned.

This morbid process in the tissues seems to have been first described, although known long before this time, in 1901, by Secrétan. Vulliet shortly after this time described the process as a diffuse, fibrous exudation in the subcutaneous cellular tissue, which lasted eight or twelve weeks.

Grunbaum recommended injecting thiosinamin combined with the hot-air application.

TUBERCULOUS CARRIES AND RONTGEN RAYS.

Freund next exhibited four cases which he was treating at his clinic with the Röntgen rays. The first was a girl about twelve years of age, with caries in the first phalanges of the index finger, which had existed for eleven years, and twice during this time the bone had been cleaned out, leaving a fistula along the bone $1\frac{1}{2}$ centimetre long, and 6 millimetres wide. The rays were concentrated on the fistula, with the result that after twelve applications the fistula healed completely up, and now assumes a normal appearance.

The other three cases were epithelioma of the face, which was first removed and the rays applied to the bottom of the wound, which healed up rapidly afterwards.

In the case of females, Freund volunteered the information that these were more susceptible to the rays than others, as the menses were rapidly induced, or if pregnant produced telangiectasis, which ought to be carefully guarded against in all our experiments.

Federn asked if this sensitive condition to the rays was more accentuated during the period, or did it affect the whole body throughout the period? Again, was it active only a short time before and during the menstrual period?

Freund replied that the action was greatly accentuated before the period, which might be induced by the fulness of the vessels, as was also the case in the gravid state. He had one case where telangiectasis occurred, although the rays had not been used during pregnancy, nor for some time before conception. He presumed this phenomenon was due to the rays having altered the blood-vessels, or varied the current in some way.

TUBERCULOUS PROTECTION.

Teleky referred to the different changes that have taken place in the treatment of tubercle within the last decennium, and concluded that in spite of the orthodox bacteriology on the subject, we had only got the length of prophylaxis of an international character. He summed up the treatment in three phrases—"Dispensaire anti-tuberculeux," personal comfort, and hygiene, with removal to a suitable sanatorium. Among the poor the latter was a necessary adjunct, as their home comforts were limited and their environment bad.

After relating a number of conditions necessary, he thought the benevolent societies and town councils of Austria were rivalling Belgium, France, and Germany in providing sanatoria and convalescent homes. Since Calmette commenced these institutions in Lille every country in Europe had followed the example

with surprising zeal and reputed success. In Vienna itself the Austrian "Hilfsverein" established its first effort in 1902; last year saw another of these benevolent institutions rise; and now we are promised another next year. The convalescent homes must be distinguished from the sanatoria, the latter for poor patients, where the disease is active, the former where no infection exists, or non-active. One family may have members in each institution under the patronage of the medical benevolent society which extends over the whole of Austria, but such institution sends its own servants to investigate the habits, status, and condition of the individual members before admission. This secures immunity from dangerous contacts, which is all important in the successful treatment of tubercle.

Escherich congratulated Teleky on the good work this guardian society had undertaken, which, according to his opinion, was the first and best treatment of tubercle.

The Operating Theatres.

GREAT NORTHERN HOSPITAL.

INGUINAL LAPAROTOMY IN AN INFANT.—Mr. PEYTON BEALE operated on a male infant, *æt.* 3 days, who had been admitted with a history of having passed nothing *per rectum* since birth. The child was very well nourished and, as far as external appearances went, perfectly developed. There was some distension of the abdomen. Upon making a rectal examination, the tip of the finger encountered a narrowing of the lower end of the sigmoid. The rectum was quite normal, and no diaphragm could be detected within it. It was considered probable that the case was one of arrested development of the colon. Mr. Beale had generally found that when there was a well-developed rectum present and the finger could be inserted to the full extent without encountering any obstruction, that an arrest of development of the transverse and descending colon, and very often of the cæcum and ascending as well, was present. He therefore advised the house surgeon, Mr. Alford, to perform a right inguinal colotomy. He did this and two or three coils of intestine distended with meconium presented; attached to one of these there was observed to be a fibrous band about a quarter of an inch in diameter, extending up towards the liver; and starting from this where it joined the distended intestine was a rudimentary vermiform appendix about an inch and a quarter long and about a sixth of an inch in diameter. A mesenteric stitch was passed beneath a loop of the distended intestines, the stitch being passed through all the layers of the abdominal wall and then drawn tight and tied under the loop of intestine. Mr. Alford then freely opened the intestine, and a large quantity of meconium escaped. The bowel was rapidly irrigated with hot sterilised water in order to clear it as much as possible and the wound dressed in the ordinary way. The operation only lasted a very few minutes; this was, of course, a matter of great importance in very young infants, and it was, Mr. Beale said, in these cases of colotomy, which had to be rapidly performed, that the mesenteric stitch was of special value. He considered that in performing colotomy in adults, it was always desirable to stitch each end of the protruding loop of intestine to the skin; prolapse was much more common in the case of the large than in the case of the small intestine.

The infant only survived ten or twelve hours, and *post-mortem* the conditions which were present were exactly as diagnosed.

ST. THOMAS'S HOSPITAL.

NEPHRECTOMY FOR CARCINOMA OF THE KIDNEY.—Mr. BATTLE operated on a very stout woman, *æt.* 52, who had been sent to him by Dr. McCarthy Morris for hæmaturia. The history of the case was as follows: The patient had enjoyed good health until nine weeks before admission, when she had been seized with severe pain in the left renal region, which ran downwards towards the bladder. Soon after the commencement of this attack of pain she had noticed blood in the urine, and although the pain subsided after a few hours, there had been blood in the urine constantly since that time. On admission, examination of the urine showed it to be darkly red in colour and to contain on microscopical examination numerous blood corpuscles with a few pus cells, but there was no evidence of abnormal cells. The left kidney could be felt on examination, and was larger than normal. The history appeared to point rather to calculus than to anything else, and it was proposed to examine her with X-rays, in order to assist the diagnosis, but the X-ray department said that the patient was too stout to give any reliable result. The kidney was explored through a lumbar incision; no stone could be felt on examination of the kidney from behind, and the only unusual condition ascertained was a fulness about the pelvis of the kidney. This was rather indefinite, and it was thought that it might be due to a deposit of fat about the hilum of the kidney, between the ureter and the vessels. An incision was therefore made in the kidney substance behind, and through this the forefinger was passed into the renal pelvis; no stone could be felt, but in its lower part there was a soft, cushiony, smooth projection, about the size of half a walnut; this, which was evidently new growth, was broken off with the finger and extracted with forceps; the base from which it had been removed bled rather readily, and the hæmorrhage was stopped by pressure. A portion of the growth evidently belonged to a larger mass involving the substance of the kidney, and was of a malignant nature; it was therefore decided to remove the kidney at once, and this was done, the pedicle and ureter being caught in the same clamp, and after excision of the kidney they were enclosed in one ligature of No. 4 silk. The growth, which was the size of a hen's egg, occupied the lower and anterior part of the kidney; it was soft and vascular, with a smooth, bossy surface. No enlarged glands could be felt. The operation was a difficult one, on account of the extreme stoutness of the patient, but she bore it well, and did not suffer much from shock. Mr. Battle said that in the absence of help from the X-ray department he did not think it was possible to come to a correct diagnosis in a case of hæmaturia commencing suddenly with severe pain only nine weeks before admission. In all cases of excessive hæmaturia of renal origin occurring in patients over middle age, the possibility of growth, he thought, must not be overlooked, and its duration will help very much in deciding whether it is of a malignant nature or otherwise. Some cases of renal calculus, he remarked, may cause hæmaturia without pain, although this is a most unusual occurrence; much depends upon various factors in the case, such as intermittence in the flow of blood, its amount, the duration of the symptom, and the effect of treatment or neglect of treatment.

In all probability in this case the attack of pain was caused by the passage of a blood clot, and was not due to obstruction of the ureter by growth, for the character of the piece which projected into the pelvis of the kidney negated any possibility of its acting as a valve.

A few days after the operation the amount of urine daily passed by the patient diminished to a few ounces, but at the end of ten days the remaining kidney was working well, and a normal quantity was being passed; the case has since progressed favourably.

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The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, JANUARY 4, 1905.

THE HOSPITAL SUNDAY AND KING EDWARD'S FUNDS AND THE ROYAL ORTHOPÆDIC HOSPITAL.

It is natural that the various Hospital Funds should seek to exercise the power put into their hands by the great sums of money entrusted to them for distribution. No readier method of enforcing their views upon individual institutions could be imagined than that of the purse, by way of the bestowal or the withholding of grants. At the same time, the interests of the public demand that, in wielding this great power, the policy of the Funds should be clearly stated. Anything in the nature of an arbitrary and autocratic executive, which gives without stint to one and withholds without explanation from another charity, cannot be tolerated in the present democratic age. With all due respect to the transparent loftiness of aim and purity of purpose of the Hospital Sunday and the King Edward's Funds, we must insist that their administration partakes more of the irresponsible methods of a Russian bureau than of the typical British trust supported by the people, controlled by representatives of the public, and freely criticised by the press. We will now proceed to inquire how the influence of the Hospital Sunday and the King Edward's Funds has been brought to bear upon the Royal Orthopædic Hospital, formerly in Oxford Street, but recently

amalgamated with the National Orthopædic Hospital. It is difficult to obtain exact proof, as the Funds rarely furnish reasons for giving or withholding grants. The Royal Orthopædic, however, was considering the sale of site in 1898, and the Hospital Sunday Fund grant in that year sank to £52 10s. In 1899 the proposal to sell the site for £28,000 by Lord Wantage, as chairman, and Sir Walter Gilbey, as treasurer, was defeated by a party led by Mr. Harry Marks, now M.P. for the Thanet division. Soon afterwards, Mr. Marks became chairman, and then, curiously enough, suddenly reverted to the policy of sale. The grants of the Sunday Fund thereupon sprang from £52 in 1898 to £78, £95, £100, £134, £81, and £100 in successive years to 1904. Will the Sunday Fund say whether the decrease and increase of grants had any relation to the question of sale of site? The secretary of the Royal Orthopædic Hospital, in the *Hospital* for December 10th, 1904, denied that the Metropolitan Sunday Fund advised his hospital to sell its site. Against that statement we hold the definite assurance of a member of the deputation, consisting of the honorary solicitor, one of the surgeons, and the secretary, that the chairman of the Fund said in so many words that the hospital should be sold. In any case the general hostility of the Sunday Fund to small hospitals is no secret. That is freely admitted by Sir Henry Burdett who, in the *Hospital* for December 3rd, 1904, speaks of the “time the Hospital Sunday Fund urged that a sale was desirable.” On the whole, it seems clear enough that the Sunday Fund has all along approved the sale of the site, urged amalgamation, and influenced the Royal Orthopædic either by reducing or by increasing grants. As to the King Edward's Fund, there is no room for doubt. The first grant to the Royal Orthopædic was one of £61 5s. in 1897, about the time when the sale of the site was first seriously discussed. In 1899 a grant of £250 was made for “rebuilding and new site fund.” Next year a grant was refused, “last year's conditions being ignored.” In 1901 £200, and in 1902 £250 were awarded towards the discharge of existing debts. In 1903 a further £200 was given, with the note: “the committee view with satisfaction the amalgamation with the National Orthopædic Hospital.” Here, in the King's Fund, there was no hesitation in saying why grants were given or withheld—an outspoken practice that may be commended to the Metropolitan Sunday Fund. On the foregoing evidence we may reasonably assume that both the Funds in question urged the sale of the Royal Orthopædic site both directly by spoken and written word, and indirectly by the granting, or, more forcibly still, by the withholding of grants. The point is, could the Funds limit their responsibility to advice upon so vital a matter without full inquiry into the facts of the sale they were urging? Was that inquiry made? If so, where are the official minutes of the information on which the Funds acted? The sale was opposed by a small but

strong minority of the hospital governors, by the *Lancet*, and by THE MEDICAL PRESS AND CIRCULAR. What steps were taken to ascertain the grounds of this opposition before the Funds gave their powerful support to the sale? Had the Funds' wishes been followed in 1899 the hospital would have lost £12,000, as the minority forced the sale price up to £40,000, and claim it is worth £50,000. Sir Henry Burdett says it was the duty of the governors to secure "the highest obtainable price for the site." (a) "The Sunday Fund," he continues, "could have had nothing to do with the price or the value of the site, and their action must have been confined to an expression of opinion in favour of its being realised and a new site found elsewhere." The Funds' opinion, however, be it noted, ceased to be pious when backed by grants. It is our contention, before they brought pressure of such an extreme kind to bear upon the management of a hospital, they should have made an exhaustive inquiry into the circumstances of the case. It may seem to Sir Henry Burdett a small thing that a hospital should lose £12,000. Philanthropists are apt to think in large figures, a fact that the Prince of Wales has discovered in the wholesale annual waste going on yearly in London hospitals. Sir Henry Burdett has had a wide experience of City matters as secretary of the Stock Exchange and director of various companies. Perhaps he thinks the finances of the Royal Orthopædic Hospital are bound to be conducted on lines of absolute wisdom by a financier of the experience of Mr. Harry Marks, especially when aided by two such well-known City men as Mr. James Head and Major Ricarde-Seaver as trustees of the charity. The minority thought otherwise, and the soundness of their opinion has been abundantly confirmed by the enhanced value of £40,000, at which the site has been sold. They further thought that, if sold at all, the sale should have taken place at Tokenhouse Yard. Was that point—urged also by various medical journals—known to the Funds? The minority thought also that a site of such great and rapidly increasing value should have been let on lease. As a matter of fact, £1,400 a year was offered as a rental for one portion only of the site. By letting on lease a permanent income would have been secured to the charity, which would at the same time have kept an enormously valuable freehold endowment in their own possession instead of squandering its purchase money in bricks and mortar elsewhere. Was that aspect of the matter presented to the council of the Metropolitan and the King Edward's Funds before they urged the sale? Did they know and not care, or did they not know and not care? Anyway, the public is entitled to learn the methods of procedure adopted by the Funds in such weighty matters. It is shameful enough that medical charities should be damaged by irresponsible amateurishness. It is a thousand times worse, however, if public trusts are to be allowed to set up as auto-

cratic bodies, entitled to play fast and loose with the properties, the prospects, and the reputations of small hospitals.

TUBERCULOSIS IN IRELAND.

IN matters of public health it is curious how difficult it is to focus the attention of the public where it can prove of any use. A few years ago, owing in great part to the personal interest shown by the King, it is true that much interest was roused in the subject of the prevention of tuberculosis, and branches of the National Association sprang up all over the country. We fear, however, that the interest of the laity was of a temporary sort, and that, like any other fashion, it has now veered into other quarters where it is of much less service. For instance, one can hardly take up a daily paper without coming on paragraphs dealing with researches into the causation and therapeutics of malignant disease, a subject which is precisely at the stage where it can only be safely dealt with by men of science. We only wish that half the energy which is now dissipated in idle curiosity as to alleged cancer cures were spent in rational work for the prevention of tuberculous disease. It is constantly demanded of medical men and men of science to explain the causes of this, that, or the other disease, but when this is done and, the public is furnished, as is the case with tuberculosis, with methods for the prevention, if not for the cure, of the disease, then but little use is made of the knowledge. We are led to these remarks by the fact that the Dublin Branch of the National Association for the Prevention of Tuberculosis, in a city of over a quarter of a million inhabitants, in spite of the energetic exertions of the honorary officers and committee, enrolled only three new life-members during the year, and that it contains in all only seventy-five paying members. And, indeed, Dublin, in this respect, is only typical of the lack of interest all over the Kingdom in this overwhelmingly important subject. It is only a few weeks since the Council in London was forced to appeal for funds to the public in a letter to the papers, in which it was stated that "the apathy of the public and the inertia of authorities charged with the maintenance and preservation of the public health have to be overcome. The further work of the Association will be seriously curtailed unless further subscriptions to the funds be forthcoming." It is a matter for rejoicing, however, that although the National Association is not supported as it deserves, much is being done to reduce the mortality from tuberculosis. In England and Scotland there has been, during the past forty years, a steady decrease in this mortality, but in Ireland the rate is stationary. In Great Britain the public bodies are gradually recognising their responsibility and duties in the matter, but in Ireland, except the educational work, done for the most part by the agency of the National Association, nothing has been done. The public bodies, with one or two exceptions, have not moved. The Dublin Corporation has distinguished

(a) *Hospital*, December 2nd, 1904, p. 180.

itself especially by its stony deafness to the suggestions alike of its own Public Health Committee and of the medical profession. We commented adversely some weeks ago on their refusal to appoint a City Bacteriologist to give assistance to practitioners in matters of diagnosis, and we are glad to see that the Annual Report of the Dublin Branch of the National Association raises the same point. Cork and Belfast, luckily, are far ahead of Dublin in dealing with tuberculous disease. An arrangement between the city of Cork and the various district councils has been come to by which a sanatorium for the consumptive poor of the city and county will shortly be established. In Belfast the Board of Guardians is about to remove to the country the two or three hundred consumptive patients at present in the union infirmary. We are glad to notice that the interest of the various religious bodies in Ireland has been roused in the subject of tuberculous disease, and at the recent meetings of the General Synod of the Church of Ireland, of the General Assembly of the Presbyterian Church, and of the Methodist Conference, resolutions on the question were adopted. The Dublin Branch of the National Association continues its excellent educative work on the community at large, and it must not be discouraged if the results obtained are not as rich as was hoped would be the case some years ago. Public bodies are hard to move, for they wait till a strong public opinion is formed, and it is only by such work as the Dublin Branch has taken in hand that this end is to be attained.

Notes on Current Topics.

Mr. Jonathan Hutchinson and Titular Honours.

It is said that henceforward the New Year's honours list will cease. The recurrence of the familiar season, however, reminds us of the curious absence of titular distinction as regards one of the most distinguished figures in the modern British world of medicine. It may be that, like John Bright and William Ewart Gladstone, Mr. Jonathan Hutchinson has declined an honour which does not appeal to his philosophical mind, and prefers that his name should go down as a commoner to posterity, whither it certainly will go. There are public aspects of the question, however, which should render the views of a particular individual to some extent amenable to more general interests. In the case of a medical man the bestowal of titular honours has a peculiar significance, as it usually recognises the distinguished work of a man eminent in a noble and humane profession, where the average reward is scanty. The most conspicuous honour of the kind is obviously that of the peerage bestowed upon Lord Lister. It is likely that his name will live for ever in the history of mankind as one of the greatest benefactors that the human race has ever known. It is right and fitting, therefore, that Lister should be recognised by

one of the highest titular distinctions available in our social system. On looking through the list of medical baronetcies and knighthoods, however, it is remarkable how many of them have been bestowed upon obscure individuals whose names are not widely familiar in their own, and will certainly never survive the cycle of a succeeding generation. Some of these titles have been given for military or naval services, and many have been given to presidents of colleges or provincial schools, while others, again, have been bestowed upon medical men whose duties have brought them into contact with Court circles. In any ideal scheme of distribution the test of titular worth would not unreasonably be made to depend upon the scientific standing and achievements of the individual. Applying that test, there is no untitled medical man in London more entitled by his sheer scientific merits to titular honour than Mr. Jonathan Hutchinson. Year after year we have seen his name omitted from the lists with a feeling of surprise and chagrin, and a growing conviction that the only possible explanation of this unaccountable omission was the express objection of Mr. Hutchinson himself to any such honour. Year after year medical knights and baronets have been created who were, from the point of view of scientific comparison, unfitted to loosen the latchet of the shoe of one of the most philosophical surgeons of the last half century. We venture to draw the attention of Mr. Balfour's Government and of His Majesty to what appears to have been an unaccountable oversight. If Mr. Jonathan Hutchinson has declined titular honour we certainly think that fact should be officially announced, or else the whole system of bestowal of such honours will sustain a most damaging blot upon its reputation.

The Examinations of the Central Midwives' Board.

We are glad to see that the Privy Council has referred back to the Central Midwives' Board the scheme of examinations which the Board submitted to the Council for approval. The Board, or rather that portion of it which has so far apparently acted whenever possible in opposition to the medical profession, decided to appoint examiners other than registered medical practitioners to examine, and, as we are informed, gave as a reason for this curious action that it would be well to have examiners who could examine in bed-making. The Privy Council has, however, put a stop to the absurd anomaly which would have rendered it possible, and, indeed, probable, for some half-trained midwife to sit in judgment on the teaching of registered general practitioners in all such medical matters as the scheme of examination included. The Privy Council considers that the examiners appointed by the Central Midwives' Board should be duly qualified medical practitioners, and that it should be optional to the examiners, when they thought fit, with the consent of the Board, to employ, for certain parts of the

examination, properly qualified women who were not medical practitioners. We congratulate Sir William J. Sinclair and those of his colleagues who opposed the Central Midwives' Board on this matter on the success of their opposition. Some little time ago, we recorded the fact that the dispute between the authorities of the Rotunda Hospital and the Central Midwives' Board had been satisfactorily arranged, and that in future nurses trained at the Rotunda Hospital would be allowed to present themselves for the examination of the Board, and we are now glad to see that the Coombe Hospital has been similarly recognised. Truly, the ways of the Central Midwives' Board are past comprehension! In the past, its method of procedure has been farcical and its actions ludicrous; it has ridden for a fall, and it has received one. Will it, in future, conduct its deliberations in, and allow its actions to be governed by, a judicial spirit? We hope so.

Medico-Legal Experimentation.

THE mysterious death of M. Syveton, following so closely upon his assault on General von André and the uproar created by his extraordinary conduct, has given rise to profound sensation in France. The various theories of homicide, suicide, and accident each have their advocates, but probably the real truth will be elicited by the inquiry now being instituted by the *juge d'instruction*. M. Syveton, it will be remembered, was found dead in his study. His body bore no marks of violence, and circumstances pointed to death having been due to coal gas, or carbonic oxide, poisoning. Madame Syveton advanced the theory that her husband had taken his own life, either by leaving the tap of a gas-stove, which he had in the room, turned on whilst he sat at his table, or by deliberately inhaling the gas as it came from the stove. It therefore became important to find out if either or both of these methods were feasible, and, if feasible, likely to be effective. As both of them suggested practical difficulties which seemed to negative the idea of suicide, appeal was made to Dr. Ogier, and he decided to put the matter to a practical test. A dog was taken and tied to the stove in such a manner that he inhaled the gas directly from the open burners, whilst two guinea-pigs were left free to run about the room. The dog made frantic struggles to get free, and did not die for nearly an hour, whilst the guinea-pigs were still alive, although unconscious at the end of that time. This evidence would seem strongly against the idea of suicide, for it would practically negative the idea that M. Syveton died while sitting in a chair away from the stove, and it would still more strongly militate against the theory that he held his head over the jet and inhaled the gas directly. Only the most determined suicide would hold himself in a strained position for nearly an hour in order to destroy his life. Whatever the eventual upshot of the inquiry may be, the evidence obtained by the experiments will be of great help to the *juge* in coming to a right conclusion,

and thus demonstrate—if demonstration were needed—the utility of experimentation on animals in medico-legal work. We tremble to think of the outcry which such an experiment would produce if performed in this country—to say nothing of it being directly contravened by the existing state of the law.

Murderer Feigning Insanity.

IT is somewhat strange that criminals when arrested for murder do not more often endeavour to evade the penalty of their crime by feigning insanity. Probably their ignorance of the real symptoms and signs of mental disease prevents them from trying to practise a deception which, if successfully carried through, would substitute a life of comparative ease for the certainty of death. Wagner (a) describes a case in which the patient, a man aged thirty-two, who had murdered his wife, pretended to be insane, and with great ability kept up the fraud for eighteen months. He appeared morose at some times and incoherent at others, and to these psychical manifestations he added certain physical ones—inability to walk, coarse tremor of the leg, and Rombergism. Although tried and convicted, he was never caught off his guard for a moment, and when the state of his mind was subsequently inquired into by a committee of experts, he wore such an imbecile expression and behaved so strangely that he might possibly have got off had not Wagner suggested that the effect of an anæsthetic should be tried. As the ether was being administered, he began to talk in a loud voice, although previously he had only appeared able to whisper, and his language was not only coherent but profane and abusive. When consciousness was fully abolished he was placed on his feet and allowed to come round in the vertical position, and then, before he was thoroughly aware of his surroundings, he was assisted to make a few steps, and then left. He continued walking, placing his feet squarely on the ground, and showed no signs of the tremor of the legs that had been constant before. The prisoner afterwards confessed that he had been malingering, and added that the strain for eighteen months had been so awful that he would rather die than endure it longer.

A Lady Dentist.

DENTISTRY would seem to be the Cinderella of the professions, so far as women are concerned. Medicine they have eagerly embraced, the ministry possesses at least one lady pastor, and the bar is only recruited from the ranks of the male sex because it churlishly refuses to entertain angels un-awares. But this stigma has now been removed—not, unfortunately, in this country—by the recent success of the Countess Helene von Schweintz in the final examination in dental surgery at Berlin. It is somewhat remarkable that a calling which demands so much neatness of hand and manual dexterity should have hitherto exercised too little

(a) *Med. News*, November 19th, 1904.

attraction for the newer womanhood, especially when many are entering paths where the qualities which generally characterise women are but little advantageous. A lady dentist in this country would be pretty sure of a *clientèle* of the curious, just as the earlier women doctors are said to have had a good many patients who came to see how they would act and what they would say. But, we fear, one can hardly hope to start with a Countess as the first female dental surgeon. Medicine has not yet drawn to its study a peer of the realm, much less a peeress. In Germany, however, things are different. There the nobility are considerably more numerous than here, and considerably less well off. Quite a number of barons are in practice as physicians, and there are at least two princes who have devoted themselves to ophthalmology. The enterprising Countess, therefore, will not find herself entirely cut off from "her own people."

Campaign Against Tubercle in the United States.

It is perhaps due to the fact that tuberculous disease does not figure so largely in the death statistics in America as in this country that our neighbours have been somewhat behindhand in the formation of a National Association for the Prevention of Tuberculosis. It is true, however, that preventive measures are practised in many of the States in a much more efficient manner than we are accustomed to. For instance, the laws against spitting in public places are much more stringent than has been found practicable at home, and thus a prolific method of spreading infection is annulled. Again, in many American cities, the public health authorities deal with tubercle and other infective diseases in the most efficient manner. Expert aid is at hand for the early diagnosis of tuberculous disease by bacterioscopic methods, and rigorous disinfection of premises is practised. Nevertheless, there is still plenty of educative work for a Preventive Association to perform, and the newly-formed body, whose executive contains the leading men in the profession in America, will, if it keeps to the programme sketched out at the inaugural meeting, find its hands full. Among the items mentioned are the erection of sanatoria and isolation hospitals, the promulgation of special legislation, the education of local Boards of Health, and a propaganda to the people by means of pamphlets, popular lectures, and articles in the press.

A Bone-Setting Romance.

THE remote districts of the Lowlands, which a few months ago sprang into unenviable notoriety from the fact that three bone-setters of extraordinary fame had elected to practise in them, seem to have lost their proud pre-eminence, for one now hears of these experts popping up in all sorts of different places. One of them has found an anchorage in Bond Street, and here he is daily being interviewed by halting patients and by

minor journalists. The visits of two of these happened to coincide—doubtless by chance—the other day, and the result was that an interesting account of the consultation and its results found its way into one of the leading morning papers. The patient was a charming lady who had been stricken with paralysis of one side of the body five years ago, but later the palsy took the curious course of "settling in both her feet." The medical treatment for this extraordinary malady seems to have been an unusual one for paralysis of the feet, namely, the application of iron supports to the outsides of the legs; anyhow, thus equipped, the paralysed lady was able to walk about. A lover in the background completed the picture, but for all the lover's faithfulness the iron supports acted as an insuperable bar to the legitimate consummation of his aspirations. This pretty romance only needed the bone-setter to act the part of the fairy queen, and in Bond Street the bone-setter was found. A few magic manipulations of the paralysed feet—the irons were discarded, and the lady walked with springy gait. The lover beamed, the journalist wrote, and the bone-setter doubtless pocketed his fee. Thus all ended happily. The interview could not be prolonged as a large number of patients were waiting to see the bone-setter. How the rest of the suffering and doubtless opulent crowd fared, however, is not recorded.

Pathology at Oxford.

WE are glad to observe that the importance of making proper provision for the teaching of pathology at Oxford is not likely to be overlooked. It will be remembered that, when the Regius Professorship of Medicine fell vacant, it was proposed to appoint the Reader in Pathology to the vacant chair, as the University was unable from any other source to make due provision for the maintenance of the pathological department. The proposal, however, met with strong objections from a large and influential body of Oxford graduates, and was finally abandoned, and, as everyone knows, the Chair of Medicine was offered to Dr. Osler. The problem of establishing the teaching of pathology on a proper basis still remains. The University chest professes itself unable to furnish funds at all adequate to the demands of the situation, or sufficient to retain the services of the present distinguished Reader. Temporary help has been given by the Rhodes Trustees, who are granting a sum of £200 a year for five years on the condition that Dr. Ritchie remains in the Readership. This timely help should allow some means to be devised to meet the situation. A meeting of Oxford men was held in London before Christmas under the chairmanship of Sir William Church, when resolutions were adopted in favour of starting an endowment fund for the permanent support of a pathological department at Oxford, and of pressing its claims for fuller recognition from the University authorities. A strong executive committee has been appointed, and some large subscriptions have been already promised. We trust that the effort

thus inaugurated by pious sons of the University will receive support not merely from Oxford men, but from the public.

Secret Commissions in Canada.

WE commented in a recent number (a) on the system of underhand commission or "grafts" which is a subject of discussion in the States. We learn from a Canadian contemporary (b) that the same noxious practice is creeping into the Dominion, and in Toronto a particularly offensive trick has just been brought before the public. A well-known physician of that city, Dr. MacCallum, received a note from the principal of an important ladies' college asking for his medical attention to one of the pupils, "subject to the usual condition that a discount of 10 per cent. is deducted by the College off fees charged to the pupils." He very properly refused to accede to any such conditions, and followed up his refusal by bringing the correspondence before the profession in Toronto, and before the College of Physicians and Surgeons of Ontario. The unpleasant part of the thing is not the impudent attempt to bribe Dr. MacCallum, but the fact that other medical men have been found who are ready to attend pupils at the College on the proposed conditions.

M. Doyen and Cancer.

FROM the highly sensational paragraphs which have appeared in the lay papers during the past few weeks, many have been led to believe that M. Doyen's views as to the causation and cure of cancer had been upheld by competent authorities. It was freely stated that the committee of experts appointed to inquire into the matter had sent in their report, and that it was conclusive on the side of M. Doyen. We learn, however, from M. Doyen's own statement to the Société de Chirurgie, what we had indeed somewhat suspected, that the matter is still far from being a *chose jugée*. The Committee's report has not yet been drawn up, nor is it likely to be so for a considerable time. One of its members, however, M. Metchnikoff, who was conducting the investigations from the bacteriological standpoint, has sent in a preliminary report. This very guarded document states that in several cases he has obtained from fragments of cancerous tumours pure cultures of an organism identical with the "micrococcus neoformans" described by M. Doyen. In other cases, however, though in a smaller number, he failed to find the organism. Of its specificity he is unable to say anything until a much longer period has been occupied in experimental work, and the same remark is made of its pathogenicity towards animals. So far, M. Metchnikoff speaks *ex cathedra* as a bacteriologist. Disclaiming, however, any right to express any opinion on clinical grounds, he, nevertheless, admits that he has "received the impression that several patients attacked by very grave cancer have been benefited

by the injections of M. Doyen." It might have been more prudent of M. Metchnikoff to have left all expression of opinion on clinical matters to his colleagues, but it will be seen that as yet matters have not been really advanced, except in so far as the existence of M. Doyen's coccus is established.

Laundry Hygiene.

THE way in which soiled linen goes through the laundry leaves little to be desired, however much it may be criticised. The accusation of wilful destruction called forth by the return of collars and cuffs, not to mention other raiment, in a barely recognisable condition, may now and then appear to be justifiable, but surely the spoiling of one's linen may be borne with a certain amount of resignation, nay, even with cheerfulness, when it is accompanied with the manifold advantages of a sepsis? Modern sanitation has undoubtedly effected great reforms in the management and conduct of public laundries in large cities, and it is comforting to reflect upon the reasonable safety and immunity from infectious disease enjoyed by customers. What though the linen does not possess quite that snowy whiteness such as is obtained from the drying-grounds of the country hill-side, may it not almost be worn by an "up-to-date" operating surgeon without any qualms of conscience? It might be supposed, however, that it is another matter with the laundry employes themselves. Theirs is all the unpleasant part of the business, and one which is commonly believed to predispose to divers affections, such as rheumatism, varicose veins, and eczema. With the object of ascertaining if such is really the case, Dr. Ira S. Wile (a) sent round a circular letter to the proprietors of a number of laundries, asking certain questions regarding the prevalence of disease among the workers. The answers he obtained show conclusively that there is no more illness among laundry employes than is the case with other workers in factories or shops. It is somewhat remarkable that in this experience not a single case of acute specific disease was contracted through handling soiled linen, which, however, was not received from places where contagious disease was known to exist. Tuberculosis was not more common than elsewhere. That "starching was the best employment for consumptives" was a view expressed by one scientist.

Loretto Dress for Boys.

THOUGH the coat does not make the gentleman yet a flannel shirt may be the making of a school-boy, at least, such is the deliberate opinion of Mr. E. N. Marshall, M.A., the headmaster of the Kingston-on-Thames Grammar School. Having spent seven years at Loretto, this worthy pedagogue was much struck by the fact that the average physique of the boys was far superior to that observed at any other public school, especially with regard to chest measurement and develop-

(a) THE MEDICAL PRESS AND CIRCULAR, December 21st, 1904.
(b) Canadian Journ. of Med. and Surg., December, 1904.

(a) Med. News, December 3rd, 1904.

ment of the limbs. Sixty per cent. of the scholars were English. The distinctive dress worn by the boys is believed to be the chief cause of their increased physical well-being. This consists in flannel shirts with collars of the same material, and flannel or tweed breeches, according to the season. The waistcoat is altogether discarded. The late Dr. Almond, founder of the school, noticed that within three months of the rejection of the latter garment an increase in the circumference of the chest was observed in nearly all cases. Combined with this costume, every encouragement is given to the boys to indulge in all forms of sport and physical exercises. Mr. Marshall has communicated with the parents of his pupils upon the subject of rational dress, advocating the adoption of the Loretto system at Kingston. There is no doubt that much of the clothing of the present day, both for children and adults, is at once both unsuitable and unhygienic. Motives of sentiment cannot be allowed to interfere with the growth and physical progress of the rising generation, and a costume which is reasonable and neither ludicrous nor ill-adapted to the movements of the body should certainly become popular. To endeavour to build up a coming race of giants by attention to collars and waistcoats, however, is to put the horse before the cart with a vengeance.

The Metropolitan Hospital Sunday Fund and Mr. Stephen Coleridge.

THE letter from the Hon. Sydney Holland published in our last issue suggests some serious considerations as regards the policy of the distributing funds and the medical charities. Here is a private gentleman, of the highest honour and integrity, the chairman of one of the greatest medical charities in the world, who feels constrained, according to his own admission, to shield the institution over which he presides from outside criticism by refusing a proffered subscription. Surely the methods of the London Hospital with regard to the disposal of its huge finances are not so weak and feeble as to be unable to withstand the wholesome breath of public criticism? If there be nothing to hide, why shrink from the questions of the Hon. Stephen Coleridge or any other man, be he crank, philosopher, knave, fool, or idiot? The Metropolitan Hospital Sunday Fund has taken upon itself to administer discipline to small hospitals, to say that under pain of loss or diminution of grants the hospital shall be rebuilt or amalgamated or what-not. Now let the Fund turn to the larger hospitals and first let it make up its mind definitely whether the London Hospital was or was not justified in spending £6,000 on a sports ground for students. That is Mr. Coleridge's question, and he has a right to be answered. Either the Hospital Sunday Fund has or has not a definite policy on the point. In any case, Mr. Sydney Holland, whose hospital draws a huge sum from the Sunday Fund, does not seem the right man to represent the views of the Fund. He is an interested party in the discussion.

Honours to Members of the Medical Profession in 1904.

It is interesting at the opening of 1905 to recall the honours that have been bestowed upon medical men during the past year. The July list of birthday honours included knightships to Dr. Thomas Stevenson, Analyst to the Home Office, Dr. Constantine Holman, best known in connection with the British Medical Benevolent Fund and Epsom College, and Mr. Kendal Franks, C.B., the Irish and South African surgeon. Several decorations were awarded in commemoration of the jubilee of the Crimean War. Among the recipients were Surgeon Thomas Ligertwood, who was made a Companion of the Bath in the Military Division. He served in the Crimea at Alma, Inkerman, and Sevastopol. Among the new Knight Commanders of the same Order were Deputy-Surgeon-General James Howard Thornton, I.M.S., C.B., and Surgeon-General Edmond Townsend, A.M.S., C.B., C.M.G. Surgeon-General William James Fawcett, A.M.S., was made a C.B., Military Division, and Hon. Colonel John Edward Squire, a C.B., Civil Division. Mr. Bolton Glanvill Corney, M.R.C.S.Eng., Chief Medical Officer of the Colonial Government at Fiji, was appointed a Companion of the Imperial Service Order. The November list of birthday honours bestowed the honour of knighthood upon Mr. Charles H. Marriott, Surgeon to the Leicester Infirmary; Mr. Shirley F. Murphy, Medical Officer of Health to the County of London; Professor William Japp Sinclair, Professor of Obstetrics at the University of Manchester; and Major Allan Perry, R.A.M.C., Principal Civil Medical Officer of Ceylon.

Medical Receptions by Public Performers.

AT present there is in Glasgow one Captain Vetrico, who styles himself the "poison-proof man," giving exhibitions in one of the places of entertainment of his ability to swallow lethal doses of certain poisons, such as strychnine, phosphorus, and so on, with apparent impunity. With these we are told he varies his *menu* by eating glass and flower-pots! Before he made his first public appearance, a number of medical men responded to his invitation to meet him in the Windsor Hotel, where he swallowed half a grain of strychnine in their presence, and also, we are told, partook in quick succession of considerable doses of Paris green, blue indigo, verdigris and so on without evil effects. This demonstration, we are further told, concluded by Captain Vetrico eating a considerable portion of a stick of phosphorus. He invites medical men to bring their own poison. A letter appeared in the *Glasgow Herald* pointing out the responsibility resting with any medical man, from a medico-legal standpoint, who should, in the event of this man's death, have supplied him with the poison. We think any doctor who procured for this man any of the recognised deadly poisons would occupy an unenviable position in the event of the man's death, and we most unhesitatingly say that life to him is always

peculiarly precarious. Recently another performer, who appeared as a hypnotist in one of the music-halls of the city, issued invitations to members of the medical profession. Evidently a number had accepted the invitation, as it was immediately announced that a large number of medical men had patronised his exhibition. Clearly members of the profession ought to exercise great discrimination in accepting such invitations, as the motive is perfectly apparent. In the case of the "poison-proof man" it is not one, we think, that ought to be encouraged with the semblance of professional approval, for it is an exhibition that can be neither elevating nor entertaining. We are in complete agreement with the *Glasgow Herald* when it said, in referring to this so-called entertainment, that "it is open to question whether a man has any right to toy with death" in that fashion.

THE attention of our readers will be doubtless arrested by the unusual number of deaths that have recently taken place in the profession. One remarkable fact is the large proportion of sudden deaths due to disease or accident. A perusal of our obituary columns of this week will bring the latter fact into prominence. Many of the recent losses have been those of distinguished men in the provinces as well as the metropolis, some of them of an old-fashioned, sterling type, of social and scientific worthiness that is by no means always to be found in the present generation.

PERSONAL.

WE are informed by the War Office that the King has been pleased to approve the appointment of Lieut.-Colonel A. Keogh, M.D., C.B., Deputy Director-General, Army Medical Service, to be Director-General, Army Medical Service, vice Surgeon-General Sir W. Taylor, M.D., K.C.B., K.H.P., retired.

SIR WILLIAM BROADBENT will give the Introductory Lecture to the spring course of Post-Graduate Lectures and Demonstrations held in connection with the Mount Vernon Hospital for Consumption and Diseases of the Chest, at the Central Out-patient Department, 7, Fitzroy Square, on Thursday, January 19th, at 5 p.m., the subject of the address being "The Examination of the Heart and What May be Learned from It."

DR. WILLIAM ST. CLAIR SYMMERS, M.B., has been appointed to the Musgrave Professorship of Pathology in the Queen's College, Belfast, vice Professor Lorraine Smith.

DR. WILLIAM GIBSON, Medical Officer of Health for the burgh of Campbeltown, was presented last week with a public testimonial, consisting of a cheque for £360 and a lounge chair, with silver salver and tea service for Mrs. Gibson, on the attainment of his fiftieth year of professional life in Campbeltown.

DR. FRED J. SCRIMGEOUR, Dundee, has been appointed to the responsible position of colleague and successor to Dr. Vartan, the well-known Scotch missionary at Nazareth.

THE Ameer of Afghanistan having applied to the Government of India for the services of a British officer to take medical charge of his household, the appointment has been approved of Major H. F. Cleveland, Indian Medical Service. Major Cleveland takes up

his residence at Kabul with a staff of native subordinates, but will retain his position in the Indian Service.

IT is announced that the new headquarters of the Manchester companies of the Royal Army Medical Corps (Volunteers) will be opened on Saturday, January 7th, by Major General M'Kinnon, Director-General of Auxiliary Forces.

DR. ANDREAS VISCHER, assistant in the surgical clinic of the University of Basle, will go out to Urfa in Asia Minor, as German medical missionary in charge of the hospital there.

THE President of the Board of Education has appointed Dr. Norman Moore, M.D., F.R.C.P., to be a member of the Consultative Committee of the Board of Education, vice Professor Bertram C. A. Windle, M.D., F.R.S., who has resigned his membership upon appointment as President of Queen's College, Cork.

MR. JOHN HENRY SALTER, J.P., surgeon, Tolleshunt D'Arcy, has been appointed to the office of Deputy-Provincial Grand Master, in the room of the late Mr. Claude E. Egerton Green.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

SCOTLAND.

CONSUMPTIVE HOMES. BRIDGE OF WEIR.—This is part of the work instituted, and for long carried on by the late Mr. and Mrs. Quarrier, both recently deceased, and it may be said of both, they did noble service in their lifetime. An appeal by Miss Quarrier appears in the newspapers, from which we gather that the eighty beds in two blocks of buildings continue to be fully occupied, and many patients are constantly waiting for admission. It is proposed to begin the building of a third block to accommodate other forty patients; £8,500 of the £10,000 required has been subscribed. It is stated that about £20 per day is required for the daily needs of the consumption part of the work. Roughly, it works out at something approaching £2 per week for each patient. We understand the diet is generous, and therefore costly, and we think the greatest care should be taken to see that the patients assimilate the food which they are required to swallow, and we say this advisedly, as it is within our knowledge that some patients adopt expedients by which they escape taking the required amount of food allotted them. The work being done is very good, but we are of those who think that some economy should be exercised in this direction. Then again, it would be well if some of those patients who are dismissed, cured or improved, could be watched for some time afterwards, as with their altered environment to stuffy rooms and spare or perhaps starvation diet, compared with what they were getting in the Homes, a relapse is very apt to take place. We say this because we know of cases where patients were dismissed very much improved—not cured—and where relapse and death ultimately followed. We are informed that some of the patients now pay whole or partial board, as far as their circumstances will allow.

GOVAN MEDICAL DEFENCE ASSOCIATION.—Some short time ago, at least three-fourths of the medical men of Govan, near Glasgow, formed themselves into the above Association for the purpose of conserving their interests and improving their ethical and professional attitude towards one another. Their aim seems in a fair way of being realised, as there was held recently a meeting of the members of the Association to present Dr. Wilson, the President, with a tangible and valuable token of their appreciation of his services. Dr. James Barras made the presentation, and in doing so he said the Association had done good work in raising the minimum visiting fee to what it was in an adjoining district. Dr. Wilson (President) in a speech enlivened

by some pawky humour, said that the ordinary Govan man was not overburdened with generosity, but that he was "not a bad sort after all," and just as he wished to get his pound of flesh, so the medical man had a right to his. He went on to explain that the society had been formed to imbue the Govan working-man with a true sense of the fact that the medical men of Govan had some rights to conserve. He would tell the working-man a few things. He should not have a child taken ill in the morning and not send for a doctor till near midnight, and he was not to run from one doctor to the other, and not pay any of them. When he changed his address he should go and tell his doctor where he had removed to, especially if he owed his doctor a nice little bill. And he should not hold to the belief, which seemed to be very common, that a doctor was bound to come at once when called upon. This was not so, unless the fee was forthcoming. The evening finished very pleasantly with social intercourse, the general tone of the meeting showing that the members were on the best of terms with each other, and were united in striving to advance the interests of the Govan Medical Defence Association.

PRESENTATION TO DR. GEORGE HALKET, GLASGOW.—On the occasion of his resigning his position as Surgeon to Court Royal Thistle, A.O.F., Dr. Halket has just been made the recipient of an illuminated address and a study clock, with a beautiful silver rose bowl for Mrs. Halket, in appreciation of his valuable services extending over the long period of 26 years as medical officer. Dr. Halket, along with Dr. I. Stuart Nairne, is one of the original members on the staff of the Samaritan Hospital for Women, and we understand he is going to devote more of his time now to the work of the hospital.

PRESENTATION TO DR. GIBSON, CAMPBELTOWN.—Dr. William Gibson, medical officer of the burgh of Campbeltown, on the attainment of the fiftieth anniversary of his professional life in the district, was presented with a public testimonial in the Town Buildings on December 27th. The testimonial took the form of a cheque for £360, a lounging chair, a silver salver, and a silver tea service, and the presentation was made by ex-Provost Greenlees. Dr. Gibson is to be congratulated on the fact that after fifty years of arduous work he still feels able to continue his duties, and wishes to go on with his work.

CONTRAVENTION OF PUBLIC HEALTH ACT IN EDINBURGH.—A modified fine of 10s. was imposed on a man the other day for having conveyed his child, suffering from membranous croup, to the Fever Hospital in a cab. It seems that the doctor who examined the child did not come to any definite diagnosis but expressed the opinion that the child should be taken to a hospital or placed under observation. The accused then became alarmed and conveyed the child in the manner stated to the hospital. In the case in question there seems little doubt that the fine was deservedly imposed, and that the child ought to have been removed in a proper vehicle. But at the same time the machinery for transferring patients to the Edinburgh City Hospital is not all that can be desired in one respect, *viz.*, that it is practically extremely difficult to get patients removed after the public health office is closed for the day. The obvious solution would seem to be to allow notifications for removal of urgent cases during the evening and night to be accepted at the Fever Hospital; but this is not done, and a medical practitioner called in the evening to a case, say of diphtheria, where tracheotomy will probably be required within a few hours' time, has perforce to delay taking steps for its removal till the following morning. This has frequently been made the subject of complaint among the practitioners, but no steps are taken to remedy the grievance.

MEDICAL PRACTITIONERS AND VACCINATION CERTIFICATES.—Some members of the profession in Falkirk appear to have adopted a novel and not very dignified method of enforcing the payment of

debts due to them, *viz.*, by refusing vaccination certificates to patients who have unpaid accounts standing against them. The matter came up at the Parish Council recently by the inclusion of such persons on the list of vaccination defaulters, and the consequent expense involved by orders being sent to the public vaccinator to attend them. The Local Government Board stated to the Council that while it was, in their view, illegal for a medical practitioner who had successfully vaccinated a child to refuse a certificate, there was no means of compelling him to do so. They advise remonstrance, and failing that a threat of prosecution of the defaulter, which would compel the patient to pay his fees and get the certificate. Would it not be far more straightforward and business-like to sue the patients directly than to resort to this indirect method of obtaining payment of just debts?

Correspondence.

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

SMALL HOSPITALS, THE FUNDS, AND THE LONDON HOSPITAL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—You write of the £6,000 invested by the London Hospital in a sports ground that the money "was devoted to the purchase of a sports ground, not as a Hospital endowment investment." What do you mean? The money was sold out from one investment—we had then about £200,000 invested—and put into this sports ground investment as one that would pay a better interest, and certainly increase in value. The investment had the double advantage of being a very excellent "endowment investment," as you call it, and also in providing our students with an excellent cricket ground which is good for the tone and *esprit de corps* of the hospital. The club were anxious to borrow the money of us and buy the land themselves, but acting on expert advice we bought the land and let it to them at a rent which pays the hospital 4 per cent. It is a travesty of words to call this a "diversion of funds," any more than if we had bought railway debentures.

I am, Sir, yours truly,

SYDNEY HOLLAND.

Kneesworth Hall, Royston, Herts., Jan. 2nd, 1905.

[Mr. Holland *confuses* the issues. Can the purchase of a site for medical schools be called a pure Hospital investment? The money was given by subscribers—either direct, or through one of the Funds—for the benefit of the sick poor—not to purchase cricket grounds for medical students.—Ed. M.P. & C.]

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

"Play fair, and do not show any personal animosity in controversial criticism."—SYDNEY HOLLAND.

SIR,—Mr. Sydney Holland's methods of controversy with me are, I believe, unique. As a person interested in hospitals and their management I venture to criticise what I believe to be an unjustifiable diversion of the funds of the London Hospital. Mr. Holland thereupon, among other epistolary elegancies, taunts me with not being a subscriber to the London Hospital. I then send a subscription. It is returned to me with impertinent allusions to my motives. Mr. Holland then makes assertions based on the accounts of the College to which I am refused access.

In such circumstances, I may reasonably be excused from participating in further discussion with him, and in any case, unless he can avoid introducing personalities into a discussion on a matter of public interest, I would rather address myself elsewhere. I think he must have discovered at the Mansion House the other day that to be personal is not necessarily to be convincing.

In conclusion, may I be permitted to say that if a

hospital manager takes upon himself to sit in judgment upon the motives of subscribers, some very large subscriptions might possibly have to be returned!

I am, Sir, yours truly,
STEPHEN COLERIDGE.

Victoria Street, London, S.W. Dec. 29th, 1904.

HOSPITAL FUNDS AND SMALL HOSPITALS.
To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR.—Though Mr. Sewill is apparently one of those who consider that repetition and argument are the same, he has gone a little too far when he speaks of the general hospitals being practically beyond criticism. H.R.H. the Prince of Wales told a very different story, and £39,000 for a beginning is a nice little sum to waste.

While it is possible that some of the special hospitals have been started without any very high motive, I would like to hear from Mr. Sewill if he knows of any physician or surgeon attached to any London hospital, general or special, who does not expect to be helped on in the world through his connection with the hospital.

Some day I hope that the question of taking fees from hospital patients will be thoroughly inquired into.

I hold no brief for any hospital—indeed, when asked to which hospital money should be given, I invariably recommend that the money be given in private charity to avoid waste. Talking on this subject lately with a wealthy man who gives largely to one of the general hospitals, I was surprised to hear him say that he was beginning to think very much the same. He had been making inquiries, and was amazed at the waste he was told of. Reform the special hospitals when needed by all means, but do not let us have any more of these unworthy flouts about advertising; we lately had an example of how to do it, where three general hospitals were represented.

I am, Sir, yours truly,
OUTSIDER.

CONSUMPTIVE HOSPITALS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR.—I am glad to see that you are directing attention to the question of the practical value of consumptive hospitals. The surroundings of the hospital at Brompton are not improving, and a very little now would lead to the neighbourhood being deserted. Very few would care to live in an atmosphere like that.

I am, Sir, yours truly,
R. L.

WORKHOUSE INFIRMARIES—COST PER BED.
To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR.—Can any subscriber give me an instance, or tell me if it is possible to erect a workhouse infirmary with administrative accommodation fitted up with modern sanitary accessories which will meet the requirements demanded by the Local Government Board at a cost of less than £90 per bed?

I am very interested in this description of work, but have never found a case where the cost was less than the sum mentioned. If anybody could enlighten me on this matter I should be very grateful.

I am, Sir, yours truly,
A SUBSCRIBER.

January 2nd, 1905.

Obituary.

DR. LOCKHART GILLESPIE, EDINBURGH.

By the sudden death on Christmas Day of Alexander Lockhart Gillespie, M.D., F.R.C.P.Ed., a career which showed every sign of brilliancy was unexpectedly cut short. He was a member of an old Edinburgh family being the son of a distinguished surgeon and the grandson of an equally well-known physician; to his own undoubted attainments were thus added the prestige which an inherited and traditional association with medicine bestows. He graduated in 1888, and in 1892 had conferred on him the degree of M.D., receiving at the same time a gold medal for his thesis. In 1894

he obtained the Freeland Barbour Fellowship of the Royal College of Physicians for original research, a field for which a critical intellect combined with an original and versatile temperament specially fitted him. The branch of medicine to which he particularly devoted himself was that of disorders of digestion, and a series of articles on this and allied topics culminated a few years ago in the appearance from his pen of a volume on the natural history of digestion published in the Contemporary Scientific series, and of a manual of modern gastric methods in which the diagnosis of diseases of the stomach was exhaustively treated. Dr. Gillespie was a recognised authority on the subject on which he wrote, and his opinion on difficult or doubtful cases was sought after and valued by his professional brethren. He held numerous important public appointments, some inherited from his father, among which his position as Surgeon to the Merchant Company, to the Institution for Incurables, and to Donaldson's Hospital, may be enumerated. For twelve years he was medical registrar to the Royal Infirmary, and in the duties connected therewith, as well as in a series of tables on medical meteorology, published monthly in the *Edinburgh Medical Journal* he found work rendered congenial by his talent for statistics. Apart from his attainments in Medicine he possessed in marked degree the journalistic sense, was an artist of considerable talent, and, like his father, excelled as a song writer. He was for many years on the staff of the *MEDICAL PRESS AND CIRCULAR*, of the *Medical Magazine*, and of the *Edinburgh Medical Journal*, and the facility with which he could write racy and sparkling articles was the envy of many among his acquaintances. He married a daughter of the late Dr. Blair Cunynghame, and is survived by three children, but his last months were saddened by the loss of his wife, who predeceased him a year ago, and he never completely recovered from the shock of this bereavement. He was in his usual health only a few days before his death, and succumbed quite unexpectedly to sudden heart failure on the morning of December 25th.

THOMAS HENDERSON POUNDS, F.R.C.S.ENG.,
L.S.A.

WITH regret we announce the death of Dr. Thomas Henderson Pounds at his residence, Friar Gate, Derby, on the 27th ult., from the effects of injuries sustained some three weeks ago while motoring. A dog ran across the road, and in the sudden attempt to avoid a collision the steering gear of the car became deflected and he was thrown out. Dr. Pounds was the son of Captain Pounds, R.N., of Plymouth, was educated at Charing Cross Hospital, and became F.R.C.S. in 1884. He was a Fellow of the British Gynaecological Society, a member of the North of England Obstetrical Society, and author of several contributions to the medical journals. In Derby he had acquired considerable reputation in surgical cases, and it was through his instrumentality that the Derbyshire Hospital for Women, an institution which does excellent work in Derby, was established. Dr. Pounds, who was only forty-eight, leaves a widow and a young family.

JAMES ARMSTRONG, M.B.ED., OF LIVERPOOL.

WE regret to announce the death, under painful circumstances, of Dr. James Armstrong, recently in practice at Rodney Street, Liverpool. His body was found at a farmhouse near Llandyrnog, where he and his family had for some time been staying. The inquest showed that death was due to the accidental discharge of a gun. Deceased was educated at Edinburgh University, where he took the M.B. degree in 1868. At the time of his death he was Consulting Physician to the Lying-in Hospital, and formerly Physician to the Liverpool Hospital for Children.

EDWARD TREHARNE, L.R.C.P. & S.ED.,
AND F.P.S.GLAS., J.P.

WE regret to announce the death of Mr. Edward Treharne, J.P. for the county of Glamorgan, with painful suddenness at his residence, Cadoxton House,

Cadoxton-Barry, on the 29th ult. He had been out during the night on professional duties. When he got up in the morning, about nine o'clock, he appeared to be in his usual good, robust health. Soon afterwards, however, he fell back on the bed and died. The deceased, who was one of the most highly-respected practitioners in the Barry district, was only forty-two years of age. He leaves a widow and two children. Dr. Treharne was the son of Mr. David Treharne, Pentre-Rhondda. He was a member of the old Barry and Cadoxton Local Board of Health, and subsequently of the Barry District Council, and had been chairman of the latter body. He also held a seat on the Glamorganshire County Council. He was public medical officer for the Cadoxton district of the Cardiff Union. He was made a J.P. for the county about five years ago.

DR. ADAM, OF LIVERPOOL.

WE deeply regret to have to announce the death of Dr. Adam, late of Shaw Street, Liverpool. The melancholy event took place on the 19th ult., at 38 Princes Avenue, where he was temporarily staying. He was educated in Dublin and took the M.R.C.P.I. in 1880, and M.D.St.And. 1880, and M.R.C.S.Eng. 1857. Up to a few years ago Dr. Adam was one of the most active members of the profession in the city of Liverpool. He was an able and well-read man, and his natural aptitude for the details of his profession, both as regards diseases and patients, amounted to what may be called genius. Although a man of firm opinions he never made an enemy, and by all who had the privilege of knowing him he was admired, esteemed and loved. He was an Irishman and one who possessed the characteristics peculiar to the inhabitants of the Sister Isle—brightness, cheerfulness, kindness, and *bonhomie*; a fine speaker, he was always listened to with even more than interest. Take him all in all, he was a typical medical practitioner of the better sort. For some years his health had been failing, a laryngeal affection, that caused breathlessness on exertion and especially when associated with a bronchial catarrh, was very hard to bear, and he himself was fully aware that his days were nearly numbered. His friends hoped for something better, but it was not to be. A deeper or more heartfelt sorrow has rarely been aroused than has been by the death of this gentleman. The writer feels that only one word can adequately describe all that Dr. Adam was to patients as well as to friends—he was essentially and intensely—human.

FRANCIS HENRY BLAXALL, M.D.ST.AND., M.R.C.S.ENG., L.S.A., R.N.

DR. FRANCIS HENRY BLAXALL, Retired Fleet Surgeon, Royal Navy, died last week at Clan Lodge, Bath, in his seventy-ninth year. He entered the Naval Medical Service in 1848, and during the Russian War was Assistant Surgeon of the *Colossus* in the Baltic, receiving the medal. He was promoted to be Staff Surgeon in 1856, took the M.D. Degree at St. Andrews in 1861, and became a Fleet Surgeon in 1869. After his retirement from the Navy he acted as Medical Inspector of the Local Government Board at Liverpool.

DR. J. R. WOLFE, GLASGOW.

WE regret to announce the death, on December 26th, of Dr. Wolfe, at the advanced age of eighty years. He took the M.D. Degree, Glasgow University, in 1856, and was elected F.R.C.S.Edin. in 1868. He was an excellent linguist, and before commencing practice in his own country, he went through the campaign in Italy with Garibaldi as surgeon on the personal staff. On returning to Scotland he was appointed Ophthalmic Surgeon to the Aberdeen Royal Infirmary, and making ophthalmology his principal study, he subsequently went to Glasgow, where he attained considerable eminence as the leading oculist in that city. Nor was his reputation confined thereto, as by his modification of the operation, as then practised; for the extraction of cataract in cases of detachment of the retina, he succeeded by aspiration in restoring the retina to its normal

position, and his name became known and his operation adopted throughout the ophthalmic world. He was the founder of the Glasgow Ophthalmic Institution, where for many years he did excellent work, and from time to time he held post-graduate courses there, which were largely attended by medical men. He was also for some time Professor of Ophthalmology in St. Mungo's College. Dr. Wolfe was a frequent contributor to the columns of this journal and was the author of one or two excellent treatises on diseases and injuries of the eye. Some few years since his health gave signs of breaking down, and this induced him to relinquish practice in Glasgow and to seek the sunnier clime of Australia, where his reputation had preceded him, and he was appointed Surgeon-Oculist to the Governor of Victoria. He returned to this country about four years ago, and had been living in retirement until his death. He leaves a widow and children to mourn their loss, two sons being members of the medical profession.

HERBERT WILLIAM KNOWLES, M.R.C.S.ENG., OF ST. HELEN'S.

WITH regret we announce the death, on December 28th, of Dr. Herbert William Knowles, a well-known St. Helens doctor, who carried on an extensive practice with his brother, Dr. Fred Knowles. The deceased was only taken ill on Friday last, when he had a heart attack, and was confined to bed. He was apparently progressing well, but subsequently had a second attack, which resulted fatally. Dr. H. W. Knowles, who was forty-eight years of age, was a native of St. Helens, and leaves a widow and a son and daughter. He was medically educated at Liverpool, and at University College, London, whence he took the M.R.C.S.Eng. in 1882.

CHARLES SMITH, M.R.C.S., BANFFSHIRE.

MR. CHARLES SMITH, of Marnoch, Banffshire, died on December 29th at the age of eighty-five. He was educated at the old Marischall College, Aberdeen, and took the M.A. degree in 1838. Four years later he qualified as M.R.C.S., and in 1892 he celebrated his professional jubilee. Mr. Smith, who had retired from practice, was one of the best-known doctors in the north-east of Scotland.

JOHN THOS. JONES, L.R.C.S. & P.ED. OF HOLY- WELL, FLINTSHIRE.

WE regret to record another death from accident in the person of Dr. John Thomas Jones, who died on Christmas Day. At the inquest held over him, evidence was given to the effect that in August last Dr. Jones was struck in the groin whilst getting into a waggonette through the door flying back. Internal complications set in, and he succumbed on Christmas Day, at the age of forty-five. Dr. Jones leaves a widow and four children. He qualified in 1884, and began practising as a surgeon and physician at Gronant twenty years ago, removing first to Llanasa and then to Lfynnongroew.

Literature.

DISEASES OF THE STOMACH. (a)

THE deservedly great name of the authors will ensure a good reception for this work, but, apart from this consideration, its intrinsic value makes it incumbent on all abdominal surgeons carefully to study its contents. Those who have followed the advance of gastric surgery, as recorded in the various journals, will doubtless find little in this book which could be called new, as Messrs. Mayo Robson and Moynihan have never been diffident about publishing their work and statistics; but it is nevertheless convenient to review their cases and conclusions in book form. The descriptions of operations are very concise and clear, and the indi-

(a) "Diseases of the Stomach and their Surgical Treatment." By Mayo Robson and Moynihan. Second Edition, pp. xiv and 508; illustrations, 108. Demy 8vo, price 15s. net. London: Bailliere, Tindall and Cox, 1904.

cations for operation well defined; but, knowing what a large number of gastric cases have been under observation by the authors, we might suggest more clinical details and more definite descriptions of mechanical and chemical aids to diagnosis in the next edition. The chapter on perforation might be greatly improved, as the description given will hardly lead to the recognition of many cases in time for successful operation, and the directions for treatment lack definiteness. It would be hard to conceive anything better than the description of gastro-enterostomy, and we heartily congratulate the authors on their brilliant results.

ENLARGEMENT OF THE PROSTATE. (a)

THIS is a volume which we can confidently recommend to the senior student and young practitioner. The anatomical and pathological descriptions are concise and quite sufficient. The clinical course of the disease is treated in a manner which shows an intimate knowledge of such cases on the part of the author, whilst the chapters on the treatment, although short, and on the whole, perhaps, not quite up-to-date, are written in such a dispassionate and broad-minded tone that they must prove useful.

Most works on this subject of late years have begun with a fight over "capsule" and "sheath," and have ended in special pleading for some one operation.

The present book is quite free from these blemishes, and although it contains nothing new, yet it is refreshing.

Medical News.

The Otolological Society of the United Kingdom.

The following members were elected as officers and members of Council for the ensuing session 1904-05:—*President*, Thomas Barr; *Vice-Presidents*, Alphonso Elkin Cumberbatch, John B. Story, Cresswell Baber; *Honorary Treasurer*, Edward Law; *Honorary Librarian*, Herbert Tilley; *Hon. Editor of "Transactions"*, Jobson Horne; *Council*, Urban Pritchard, Arthur Whitehead, Logan Turner, Arthur Cheatle, Richard Lake, Ernest Waggett; *Honorary Secretaries*, Hugh E. Jones, Macleod Yearsley.

Vital Statistics.

THE deaths registered last week in eighty great towns of the United Kingdom corresponded to an annual rate of 19.4 per 1,000 of their aggregate population, which is estimated at 17,139,295 persons in the middle of last year. In the preceding three weeks the rates had been 21.6, 18.5, and 19.2. The highest annual death-rates per 1,000 living, as measured by last week's mortality, were:—from *all causes*, 17.0 in Edinburgh, 17.6 in London, 20.6 in Belfast, 23.7 in Glasgow, 24.5 in Dublin, 25.0 in Bury, 25.3 in South Shields, 25.5 in Newcastle-on-Tyne, 25.6 in Rhondda, 26.5 in Manchester, 27.0 in Stockton-on-Tees, 28.5 in Tynemouth, 29.1 in Middlesbrough, 31.9 in Huddersfield, and 32.6 in Hanley; from *measles*, 1.3 in Nottingham and in Rhondda, 1.4 in Liverpool and in Merthyr Tydfil, 1.8 in St. Helens, 2.0 in Stockton-on-Tees, 2.2 in Stockport, 3.1 in Grimsby, 3.3 in Wigan, and 4.8 in Devonport; from *scarlet fever*, 1.3 in York, and 1.6 in Hanley; from *diphtheria*, 1.6 in Hanley, 1.7 in Wigan, and 1.8 in East Ham; from *whooping-cough*, 1.3 in Rhondda, 1.4 in Norwich, 2.0 in Tynemouth, 2.7 in Preston, and 2.9 in Halifax. One death from *small-pox* was registered in Gateshead, but none in any other of the large towns.

Plague at Bangkok.

The suspected outbreak of plague at Bangkok has been definitely confirmed. Two more deaths have occurred. It is hoped, however, that it will be possible to prevent the disease from spreading.

Alleged Poisoning on a Honeymoon.

DR. IVAN BRAUNSTEIN, a well-known physician, of

Munich, has been arrested on a charge of poisoning his wife under peculiar circumstances. After his marriage early in the year with a wealthy young lady from Halle, the newly-wedded pair started for Italy on their honeymoon. Frau Braunstein died on this journey, and it is now alleged that her husband mixed poison in her food at various hotels in such a way that her death was gradual. His object, it is stated, was to obtain sole possession of his wife's wealth. The case has created intense interest throughout South Germany.

Allingham Scholarship.

MR. HERBERT WILLIAM ALLINGHAM, F.R.C.S. Eng., by his will bequeathed £2,000 or the residue of his estate, if less than that sum, to St. George's Hospital, to found a surgical scholarship to be named the "Herbert Allingham Surgical Scholarship," the sum to be invested separately, in permanent funds, and 10 guineas out of the income are to be paid to the examiner for the scholarship annually and the residue of the income in such way as the governors of the hospital may direct.

The Status of Hospital Ships.

THE International Convention concerning the status of hospital ships in war time was signed at The Hague by the following States:—France, Germany, Russia, Austria-Hungary, the United States, Holland, Belgium, Denmark, Spain, Greece, Luxemburg, Portugal, Roumania, Servia, Japan, China, Korea, Siam, Mexico, and Persia.

The Gresham Lectures.

DR. E. SYMES THOMPSON will deliver a course of lectures on "Evolution in the Vegetable Kingdom," at Gresham College, Basinghall Street, E.C., on Jan uary 17th, 18th, 19th, and 20th, at 6 o'clock. The lectures will be illustrated by diagrams, and are free to the public.

PASS LISTS.

University of London.

THE following passed the M.D. Examination for Internal and External Students (Branch I Medicine), during December, 1904:—Wm. Maurice Anderson, B.S., Alfred Armer, Joseph Hugh Arthur, Joseph Barnes Burt, Janet Mary Campbell, B.S., Archd. Robt. John Douglas, B.S., Ronald Hatfield, Herbert Charlton Jonas, B.S., Frederick Samuel Langmead, Joseph John Scammell Lucas, B.A., Greer Edmund Malcomson, William John Morrish, Eugene Michael Niall, B.S., Ralph Norman, Harold Edward Ridewood, Charles Newton Sears, B.S. (obtained the number of marks qualifying for the University Medal), Arthur Rendle Short, B.S., B.Sc. (University Medal), Ernest Wethered, Owen Thomas Williams, B.Sc., Louisa Woodcock, B.S., Guy Theodore Wrench, B.S.

The following passed the M.S. Examination for Internal and External Students:—Frank Barnes, Reginald Cheyne Elmslie (obtained the number of marks qualifying for the University Medal), Lawrence Jones, Cyril Alfred Rankin Nitch (University Medal), Florence Elizabeth Willey, B.Sc., Ernest Eric Young.

Society of Apothecaries of London.

DURING the December Examinations the following candidates passed in:—

Surgery.—W. Archer, J. J. Comerell (sections I. and II.), P. C. Franze, F. E. Gubb (section I.), M. E. Jeremy (sections I. and II.).

Medicine.—J. J. Comerell (sections I. and II.), W. L. Crabtree, P. C. Franze, J. A. R. Wells (sections I. and II.), P. B. Whittington (sections I. and II.).

Forensic Medicine.—P. C. Franze, F. E. Gubb, W. V. Pegler, A. F. Reardon, P. L. Vawdrey, R. J. S. Verity, P. C. West, P. B. Whittington.

Midwifery.—D. L. E. Bolton, J. J. Comerell, P. C. Franze, F. E. Gubb, C. F. Kernot, J. W. Rollings.

The L.S.A. Diploma of the Society was granted to the following candidates, entitling them to practise Medicine, Surgery, and Midwifery:—W. Archer, P. C. Franze, and P. B. Whittington.

(a) "Enlargement of the Prostate: its Treatment and Radical Cure." By O. Mansell Moullin, M.D. Oxon., F.R.C.S., Third Edition. 8vo. Pp. xii+304. Price 6s. London: H. K. Lewis, 1904.

Notices to Correspondents, Short Letters, &c.

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

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.

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 re-forwarding 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.

MEDICAL CERTIFICATES.

At Merthyr on Thursday Mr. Frank T. Jones appeared on behalf of the managers of the Gelligaer elementary schools, to prosecute several parents for not sending their children regularly to school, and he complained that medical practitioners in the parish gave medical certificates with too much ease, with the result that the attendance throughout the district had fallen off considerably. Sir T. Marchant Williams, the learned Stipendiary, said the bench attached very little importance to medical certificates. They could not act upon these certificates; but if the doctors came to court themselves and gave evidence, then they could give due weight to their testimony.—*Western Mail*.

H. K. WRENCH (Bangor).—(1) Little is now heard of scoury, although there were some cases, we believe, in the South African War, and some have been reported from the Far East in the present Russo-Japanese War. Want of fresh food generally is a more correct way of describing the cause than merely want of fresh vegetables. It has been shown that the malady may be induced in the absence of fresh animal food, even when there are plenty of fresh vegetables available. (2) A copy of the issue you mention can be had by applying to the office of this journal.

A DOCTOR'S JOKE.

Dr. Little Glenfalls, of New York, is said to have sent a thousand patient's a handsome silver spoon inscribed, "Dedicated to the patients who have survived my practice." The presents cost over 2,000 dollars.—*Lafayette*.

R. F. W. (Leicester).—Stones in the kidneys occasionally reach very great size: an ever-present danger is rupture. In one case death followed rupture of the kidney in a football player who suffered from a large unsuspected renal calculus.

W. A. SMITH.—Consult one of the medical dictionaries: you will find all the information you seek in Gould's larger dictionary, an excellent work.

A. E. MALDON.—If you take our advice you will write at once, whether you are a member of the Society or not, to A. J. Bateman Esq., M.B., Secretary Medical Defence Union, 4 Trafalgar Square, London, W.C.

THE OLD MEDICAL BOTANISTS.

BECAUSE of the familiar little blue Lobelia we can never forget Matthias de L'Obel, that ever doctor who travelled about Europe studying plant life, and who practised medicine in Holland before he came to England to be physician and botanist to James I. It is noteworthy that the botanists of those days were almost invariably physicians too, for mineral remedies were practically unknown, and hence it was to doctors, in their search for new remedies in their profession, to whom plant study naturally fell. Therefore there was nothing strange or derogatory in the fact that Matthias de L'Obel had charge of Lord Zouche's garden at Hackney, in addition to, or perhaps even as an aid to, his medical work. An old engraving in the Tyase Library at Hackney, presents him as a venerable old man with a noble forehead and bushy beard, holding a flower in his hand. He was so far in front of his contemporaries that it is in his writing that we first find the rudiments of a scientific classification of plants.—From "The Leisure Hour," for January, 1905.

R.R.R.—The law is clear on the subject whether applied to the individual or combination of persons, prohibiting any one to take charge of the insane or idiots unless specially licensed under the Act.

Meetings of the Societies, Lectures, &c.

THURSDAY, JANUARY 5th.

ROYAL SOCIETY (29 Hanover Square, W.).—8.15 p.m. Mr. C. E. S. Phillips: (1) Description of an Automatic Vacuum Pump (the

apparatus will be shown at work); (2) Exhibition of a Method by which Strongly Adherent Films of Aluminium may be applied to Glass; (3) A Note on the Colouration of Glass by Radium Radiation.

NORTH-EAST LONDON CLINICAL SOCIETY (Tottenham Hospital, N.).—4 p.m. Discussion on the Medical-Legal Aspects of Alcoholism (opened by Dr. A. J. Whiting).

Bacancies.

Clayton Hospital and Wakefield General Dispensary.—Senior House Surgeon. Salary £180 per annum with board, lodging, and washing. Applications to the Hon. Secretary, Clayton Hospital, Wakefield.

Clayton Hospital and Wakefield General Dispensary.—Junior House Surgeon. Salary £90 per annum, with board, lodging, and washing. Applications to the Hon. Secretary, Clayton Hospital, Wakefield.

Borough of Scarborough.—Medical Officer of Health. Salary £250 per annum. Applications to D. Arthur Nicholl, Town Clerk Town Hall, Scarborough.

Hospital for the Insane.—Assistant Medical Officer. Salary £100 per annum. Applications to the Medical Superintendent, the Lawn Hospital, Lincoln.

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

Lancashire County Asylum, Winwick, Warrington.—Assistant Medical Officer. Salary £180 per annum, with furnished apartments, board, attendance, and washing. Applications to the Medical Superintendent.

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

Royal City of Dublin Hospital.—Resident Medical Officer. Applications to Mr. G. Jameson Johnston, F.R.C.S. (See Advt.)

Appointments.

GOLDBIE, F. M. M.D. Edin., Public Vaccinator to the Woodford District of the West Ham Union.

GROVES, E. W. HET, M.D., B.S., B.Sc. Lond., L.R.C.P., M.R.C.S., Demonstrator of Anatomy at University College, Bristol.

JONES, E. T., M.R.C.S., L.R.C.P. Lond., Certifying Surgeon under the Factory Act for the Helston District of the County of Cornwall.

LAPAGE, C. P., M.B., Ch.B. Vict., Senior Resident Medical Officer to the St. Mary's Hospital, Manchester.

PARK, A. GLEN, M.D. Glasg., Certifying Surgeon under the Factory Act for the South Bolton District of the county of Lancaster.

PICTON, GUY BROUGHAM, M.B., B.S. Durh., District Medical Officer to the Redruth (Cornwall) Board of Guardians.

PRICE, FLORENCE M. S., M.B., Ch.B. Edin., House Physician to the Swansea General and Eye Hospital.

SCHOSTEIN, GUSTAV, M.D., M.A. Oxon., F.R.C.P., Physician to the Brompton Hospital.

STOCK, W. S. VERNON, M.D., B.S. Lond., L.R.C.P., M.R.C.S., Demonstrator of Anatomy at University College, Bristol.

Marriages.

HAMOND—TILLEY.—On December 29th, at St. Peter's Church, West Hants Hill, near Bridgwater, Philip William Hamond, M.B. Lond., M.R.C.S., &c., son of J. Blomfield Hamond, of Upper Norwood, to Francis, second daughter of Mrs. Tilley and the late Edward Tilley of Hants Hill.

HARLEY—BLAGDEN.—On December 29th, at Stone Church, near Aylesbury, Edward Vaughan Berkeley, son of the late George Harley, M.D., F.R.S., to Mary eldest daughter of the Rev. Canon Blagden, Peverel Court, Aylesbury.

LE BAS—DE CRESPIGNY.—On December 29th, at St. Peter's, Eaton Square, London, Dumaresq Le Bas, R.A.M.C., only son of the late Dumaresq Le Bas, of Monte Video, Uruguay, to Mary de Crespigny, widow of Robert de Crespigny, of Sandy Mount, Dublin.

MAURICE—GIFFARD.—On December 27th, at the Church of St. Michael and All Angels Overton, Wilts, Thomas Hector Molesworth, Lieut. R.N., H.M.S. "Bulwark," son of J. Blake Maurice, M.D., J.P. of Lloras House, Marlborough, to Cicely, second daughter of H. Eyecroft Giffard, Esq., J.P., of Lockeridge House, Marlborough.

WRIGHT—TERRELL.—On December 29th, at St. Mary Abbott's, Kensington, George Angus, M.B. B.C. Cantab., youngest son of Hugh Wright, Esq., J.P., of Alniory, Wigtownshire, to Nellie Noel, eldest daughter of Gilbert Howard a Beckett Terrell, Esq., of Great Fishall Hall, Tonbridge.

Deaths.

HOLDSWORTH.—On December 28th, at 5 Sinclair Gardens, Kensington, W., John Hall Holdsworth, Esq., M.D., aged 94, son of the late Joseph Holdsworth, Esq., J.P., Coplow House, Leicestershire, and Lord of the Manor of Ellenden.

KNOWLES.—On December 28th, at Harshaw Street, St. Helens, Herbert William Knowles, M.D., aged 48 years.

WATTS.—At 5 Upper Addison Gardens, Kensington, Anne Watts, widow of the late John Watts, M.D., of Shrewsbury aged 86.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

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No. 2.

Vienna Clinical Lectures.

THE CLINICAL VALUE OF RADIOGRAPHY IN TRAUMATIC INTRA-MUSCULAR OSTEOMAS.

By DR. R. KIENBÖCK,

Principal of the Radiographic Institution, Vienna.

[SPECIALLY REPORTED BY OUR VIENNA CORRESPONDENT]
PART II.

CASE IV is that of a saddler, æt. 19, who when examined by the rays had six weeks previously fallen on his right elbow, which had become greatly swollen and painful. Mechano-therapy had been applied with no success. At the time of examination extension was very limited, but no œdema. In the sulcus of the bicipitalis internus a hard, irregular and movable tumour about the size of a child's fist could be felt. The Röntgen rays revealed a long pediculated shadow as seen in Fig. 3 in front of the humerus, 6 centimetres long. The fine attachment was 1 centimetre broad and 2 centimetres long, oval in shape, and irregular on the surface. Its constituents appeared in bands and layers, with a large white area on the inner side of the growth. At the level of the fossa olecrani fine bands could be seen passing backwards to the humerus. When the shadow was taken from behind, the neoplasm could be seen rising 4½ centimetres above the epicondylus. Fine fibres could be seen entering the epiphysis of the humerus laterally. When viewed laterally, another shadow of small dimensions was observed to be connected with the distal posterior part of the humerus. No injury could be observed about the extremities of the bones around the joint. Six weeks later the conditions were much the same. Moseitig finally operated to relieve movement, and removed all the bony structure from the brachialis internus with its insertions into the ulna.

Case V was a boy, æt. 14, who received a contused wound on the right elbow, which under the rays showed the arm in a half-flexed condition, with pain on movement. Above the joint was impacted a bony hard tumour among atrophied muscles, irregular on the surface and immovable, commencing at the epiphysal line, and extending 8 centimetres upwards parallel with the humerus. At some places it was near the humerus, at others more adjacent to the skin. On the posterior side of the humerus a small, thin shadow could also be observed. No abnormal changes could be found in the bones about the joints.

Case VI was a young man, æt. 19, who fell on a hillside and dislocated his elbow, which was speedily reduced, leaving a good deal of swelling. A few weeks after a distinct hardening took place, with a hard swelling about the size of a walnut, irregular surface, and lying in the sulcus of the bicipitalis internus. The medical radiogram revealed a well-defined shadow between the elbow-joint and plica cubiti,

arising from the front of the diaphysis of the humerus, with thin, spiny connections. The whole appearance was arrow-like, 4 centimetres long, with an isolated portion in the brachialis internus. It appeared to be composed of bone, cartilage, and fibrous tissue. A clear, fine fibre could be seen extending into the distal end of the humerus. Posteriorly there was also a dark shadow to be observed. Humerus, ulna and radius were perfectly healthy.

Case VII.—A female, æt. 28, was thrown from an automobile and dislocated the elbow, followed by pain and swelling. After reduction, the arm was carried in a sling for several weeks till it became stiff. Eight weeks after the accident the Röntgen rays were applied, when the arm could not be extended beyond 70°. Movement passively was difficult, pronation and supination impossible. Fracture or injury to the head of the radius was suspected, although there was no deformity beyond a hard swelling in the brachio-radialis muscle. The radiogram proved the bones to be entire. Behind the humerus was a dark shadow, which was uneven, as well as one in front having connection with the capsule. Higher up was another shadow about the size of a bean, oval, and lying in front of the diaphysis.

Case VIII was a man, æt. 30, who received an injury to the right elbow from the butt end of a gun in recoil while hunting. Swelling, pain, &c., took place much in the same way as in the preceding. The radiogram revealed a dark shadow in front of the humerus under the green coloration of the skin on the right arm where the gun had recoiled. The biceps had a bony hardness with no pain. This hardness was not evenly distributed, but arranged in bands along the muscle, passing well behind the humerus into the fold of the axilla; this all appeared confluent in the radiogram. Three points should be noted in this case:—(a) In the region of the axilla one of these hard masses about the size of a hazel nut had a fine shadow connection with the bone, measuring 35 millimetres from the humerus; (b) a section 2 centimetres thick stood out as a separate dark band; (c) at the distal end of the humerus two other sections appeared, both tapering into one centre at the lower end of the bone, with a fine pedicle 11 centimetres long.

In these eight cases I have just cited we have a complete picture of the course taken by a typical intra-muscular osteoma arising from a simple accident, of which there are another twenty recorded in literature on the subject, of which twelve are in the quadriceps cruris, six in the brachialis internus, one at the insertion of the deltoid, and one in the latissimus dorsi, most of these having been operated on and confirmed by the microscope.

In my own cases, the reader will observe six of them were located at the elbow with ossification of the musculus brachialis internus, Cases 3 and 4 being confirmed by operation. In both these cases the osteoma was movable. In No. 3 no connection was observed with the skeleton, while No. 4 had a pedicle connecting it with the ulna. In the other four cases the osteoma was connected with the humerus.

It will be seen from my own cases that they are not in accord with the others, which had the greatest number connected with the quadriceps cruris, while my own have the greatest number in the brachialis internus. This is not a matter of much consequence as the numbers are not great enough to determine the frequency of site. What is common to all is the injury either in the form of distortion, stretching or luxation, having in all cases a common clinical symptom. The manner of ossification in the supinator muscles or the biceps brachii, as recorded in my seventh and eighth cases, is not common to the disease, but the nature of the accident in No. 8, which was from the recoil of a rifle, is a peculiar cause of the lesion, which may also be noted here, as dislocation at the elbow-joint is the most common cause. It is worthy of note that this case was associated with osteo-arthritis, as the radiogram showed changes on the surface of the articulations and ossification of the capsule, with slight atrophy of the spongy portion at the end of the long bone, which accounted for the ankylosis of the elbow-joint.

The next character to be noted is the time taken before the growth becomes fully developed after the accident. In my own cases the first had reached its full size after six weeks; in the second case it was seven months after the accident before it reached its full size; in the third case it was eight weeks; in the fourth it was six weeks; in the fifth it was four weeks; in the sixth it was five weeks; in the seventh case it was seven weeks; and in the eighth case it was only three weeks. It seems, therefore, that after a definite time the osteoma remains stationary, which may guide the operator in determining whether an operation is necessary or not. This corresponds with Schuler's results, which gave the limits of the growth from a fourth of a year to two and a half years after the accident, which occurred mostly in his cases in the femur. Another point to be remembered is that after extirpation there is no return, and that those that have been operated on radically show an anatomical connection with the periosteum, and that near the end of the long bones.

In closely examining the radiogram we find the dark shadow confined to particular sites, having an elongated appearance, parallel with the long bones, and usually a pedicle near the diaphysis. The centre of origin does not seem to be circular, but springs from one part, particularly the anterior side of the forearm, although sometimes it may be slightly lateral in the femur; as a rule confined to the elbow in the upper extremities, and the femur at its lower third or just above the patella in the leg. Sometimes the pedicle is so small that it may pass unobserved in the radiogram. In the upper arm, Case 4 is a good example of the pedicle being obscured where the osteoma appears in front of the humerus; although the pedicle can be traced to the head of the ulna, yet the ossification occurs in the brachialis internus, which may anatomically be explained by the insertion of the tendon. When the tumour is large and round, lying in front of the humerus without any connection, such as in Case 3, but movable, the presumption, though no pedicle can be observed by the rays, is in favour of an osteoma. At the beginning of the formation of the tumour, little or nothing can be seen by the rays till the fourth week has been reached, when a fine outline can be detected in the shadow lying above the diaphysis and having the appearance of bony attachment. About this time ossification usually sets in, although the shadow has a clear centre with a distinct outline. About the fifth or sixth week the hardness can be observed on palpation, the shadow having still the same outline, with a clear centre, as in the third or fourth week, though its circumference has not increased. This is well shown in Cases 5 and 8, three or four weeks after the accident, which agrees with Rammstedt and Grünbaum's observations in the leg. It is common knowledge that new formations of bone tissue before the deposit of lime takes place, such as in the callus of fractures, are transparent and not easily detected

by the rays. Berndt tells us that nothing abnormal could be observed with the rays, although an operation had to be undertaken to remove an osteoma which occurred in a youth, and which was very porous when removed. The density and saturation of the osteoma, therefore, must be considered in diagnosing these growths by the rays, though technical skill is absolutely essential in their detection, as the intensity of the shadow is a diagnostic feature. However, in a large femur three weeks after the accident with a bad diaphragm, the osteoma should be observed. In examining the neoplasm more closely the growth is found not to be homogeneous, but contains several clear areas, sometimes pressed into one region of the growth. The surface of the growth has its elevations and depressions like a land perspective, which often leads to confusion in the diagnosis by isolating it from the diaphysis. A few weeks later the shadow becomes darker and more saturated like the diaphysal end, with internal streaks and spots which, lying parallel to one another, form laminae.

Koehler records a case where this rapid progress did not occur, but took five years to reach this stage. Schuler tells us of one of his that took three years, but as a rule six to eight weeks are sufficient. In old typical cases the shadow gives a connection with the diaphysis of the long bone, although a space is sometimes observed, and no pedicular connection can be seen with the rays. This may be easily confounded with an effusion from the periosteum into the muscular tissue, where ossification and organisation of blood clot may take place, but with careful observation the clear centre in both may be differentiated by the surroundings and palpation. The porous framework of the osteoma and the striped ossification, which prefer the sheaths of the muscular fibre, are unmistakable signs. The real worth of this knowledge by means of the radiograph is interesting as well as useful to the practitioner. In clinical practice he will often meet with hard tumours in this position whose history is uncertain, but it should always be borne in mind that these osteomas have a history of some accident a few weeks prior. They are usually hard and resistant, having neither pain nor oedema, which may lead the clinician to conclude that a fracture had existed, and that callus, and probably a spike of bone, have become organised. In the brachialis a fracture of the head of the ulna or the capitulum of the radius may be mistaken for the neoplasm.

Osteo-myelitis or sarcoma of the diaphysis is another error that might occur. Syphilitic bands in the muscles and myositis ossificans progressiva are other blunders that may be made. In the case of syphilis other parts of the body would be affected, while myositis has a multiple arrangement, and may be found in the muscles of the neck, back, and other parts of the body. In the case of intra-tendinous ossification, confusion of the diagnosis may be at first experienced, but this will be found in other parts of the body, such as the calcaneum and other prominent parts, as an exostosis of the bone sending ramifications into the tendon of the Achilles and the plantar aponeurosis. These ossifications are generally bilateral, arising from slight injuries, and are usually accompanied by slight pain.

According to the diagrams given by Virchow, many of these require careful diagnosis, especially when occurring above the patella and elbow-joint. Arthritis and bursæ occurring after dislocations are other sources of error; while ossification of the tendons of the triceps or quadriceps may be equally misleading. In cases of fracture about the joints with a thick deposit of callus, rupture of the tendons and subsequent ossification, or a fracture of the angle of the olecranon, are all fertile sources of error.

Rosaneo reports a case bearing on this subject worth repeating. A child in its fifth year, of a rachitic nature, suffered from an osteo-clasia in the left tibia about its lower third, which formed a pseudarthrosis on healing. The fibula thickened from functional activity, but subsequently commenced to bend below

the fracture in the tibia, causing a rotation of about 90° outwards. The Röntgen rays revealed a band with an overlapping resembling a new growth in the neighbourhood of the fracture, which apparently lay over the lower and upper third of the bone. From this bony deposit lying over the fracture, extensive lineal projections radiated both up and downwards, giving all the appearance of an intra-muscular deposit. This is not an uncommon phenomenon, as the fibrous tissue at this point has a tendency to calcify with the tibialis anticus. On this account statistics of intra-muscular fibrous tissue and fascia bulk largely in all fractures and injuries about this region, which has been by some termed functional ossification from the callus thrown out at the fracture. This change may be compared with the arthropathy in tabes and syringo-myelitis, osteo-malacia puerperalis and hypertrophic tuberosities. Henrad records one of the latter cases, where a blacksmith got a kick from a horse on the right shoulder. On examination with the rays an enormous exostosis was seen on the right clavicle, which had developed after pain, swelling and functional impairment of the shoulder-joint. Hence the term traumatic exostosis, which is another name for intra-tendinous ossification, and, by closer reasoning, may be the same as intra-muscular osteomas, the site of the bony deposit being the only difference in the pathology. It seems, however, that different muscles by their insertions into the bone are more prone to this change than others, as we find the brachialis internus more frequently ossified than any of the others.

Whether we can connect apophyical, periosteal, and tendinous exostoses with cartilaginous ossification requires finer argument, but the anatomy must be the guide in radiography. It should be borne in mind, however, that all this argument brings us back to the difficulty we commenced with, that it was in the spongiosis of the diaphysis where the intra-muscular excretion commenced, extending along the long bones between the muscles and their fibres, and might properly be termed epiphysial cartilage. The intra-muscular osteoma might be diagnosed from the more compact cortical diaphysis by being more porous in consistence than the bony structure covering the extremities of bones, although their origins are not far apart. In this light Constin may be correct in his conclusion after all, that genuine typical traumatic intra-muscular osteoma was only "exostose ostéogénique," i.e., cartilagineaire.

In conclusion we may accept Wolff's law of the pathogenesis of bone, that it is a functional adaptability in the structure of a tissue that proceeds to form bone, and that fibrous tissue, when injured by the skeleton, such as luxation, fracture, or contusion, will excite it to calcify. He qualifies this with normal and abnormal tissue, the former being accepted in this case, but where the trophic centres are at fault such as in tabes, syringo-myelitic arthropathy, myositis ossificans, &c., the conditions are altered. In the child genuine myositis ossificans does not commence with calcification of the tissue in the primary stage, but with an enfeebling, or weakening, of the fibrous tissue, with subsequent ossification of the structure. It should be remembered that muscular tissue does not produce calcification, neither are its fibres calcified by atrophy, but the calcification and growth of the fibrous tissue may cause the muscular tissue to atrophy and disappear, but in no case is the converse true. This theory of traumatic functional injury may explain ossification in the intra-muscular fibrous tissue, but it still leaves us without adequate reason for the enormous growth and character of the neoplasm that follows. It is possible, as suggested, that fibrous tissue, or a certain class of these, may have functional centres that, when excited, form osseous structures in certain regions, but as yet we have no definite proof to support such an hypothesis, however plausible.

PLAGUE has broken out at Port Florence. Six cases and four deaths are reported

Original Communications.

STRYCHNOS TOXIFERA (BENTH.)
AND OTHER PARALYSERS
OF THE
MOTOR NERVE-ENDINGS. (a)

By GORDON SHARP, M.D.Ed.

At the outset I may remark that all my experiments were conducted on male summer frogs (*Rana temporaria*), and in all the experiments conducted in Great Britain the frogs were pithed, and in all the experiments dealing with action on the motor nerve-endings the main leg artery of one side was tied in the usual manner. In a few of the injection experiments the animals were not pithed, and these were conducted outside Great Britain. Every experiment was controlled. Neither female frogs nor winter frogs were employed, because of the unsatisfactory results which they often yield. Unnecessary details are as far as possible left out, and this communication is only to be looked upon as a statement of the general results obtained.

In 1595-96 Sir Walter Raleigh sailed up the Orinoco River in search of the fabled El Dorado, but had to return without gold. He, however, brought with him that which, perhaps, gave greater pleasure to his scientific mind—namely, a supply of the arrow poison of the Makushi Indians, the wonderful curare. This was its first introduction to Europeans. Its composition was a secret and it remained so till about the year 1799, when Humboldt and Bonpland asserted that, despite the various substances entering into the composition of curare, its active agent was really an extract of *Strychnos toxifera* (Benth.), or other species of the South American vine Urali, and belonging to the natural order *Loganiaceæ*, the order to which *S. nuxvomica* (Linn.) also belongs. In 1812 Waterton, the famous Wakefield traveller and naturalist, paid a special visit to British Guiana to obtain a supply of the poison, his object being to test its efficacy as an antidote in snake-bite. On his return to Wakefield he demonstrated its action as an antidote in the house of Dr. Hobson, of Leeds. Unsuccessfully, I may add. To-day we know that both curare and snake poison in one phase of their action at least are alike, for they both paralyse the ends of the motor nerves. Later, Robert Schomburgk, as the result of his travels, was able to say that the strongest poison as prepared by the Makushi Indians could be prepared from the bark of *S. toxifera* or *S. Schomburgkii*. Up to this period the precise manner in which curare acted remained a question of conjecture, and it remained for Claude Bernard to show, in 1857, that its action was to paralyse the motor endings in the muscles.

To return a little. Although Humboldt, Bonpland, and Robert Schomburgk had all been able to prepare an extract from species of South American *Strychnos*, which at least appeared to kill like curare, there yet remained an element of doubt as to this plant being the only really active agent entering into the composition of curare. There was further some reason for this element of doubt, because Richard Schomburgk (brother to Robert) published in 1879 a pamphlet in which he stated that the tribes of the rivers Amazon and Rio Negro do not employ a *Strychnos* species at all in the fabrication of their curare. More, Dr. T. L. Bancroft and Professor de Lacerda, of Rio Janeiro, till within the last few months maintained that curare did not owe its action to a *Strychnos*, and I shall refer later to the plants they believed were at least identical in action to those entering into the composition of curare. Thus it was left to be proved that a species of South American *Strychnos* had an action similar to the commercial curare. This was not an easy matter to settle, for it is most difficult to obtain a supply of any species of *Strychnos*. Four years ago I tried every possible source to get a supply at any cost, but all I could get was a very small quantity of the scrapings of a bark

(a) Read at the Therapeutical Society.

reputed to be *S. toxifera*. A few years ago a well-known German alkaloid maker sent a medical man to British Guiana to buy a supply of the plant, but after remaining some months in the Colony he had to leave without having effected his mission. The causes of the difficulty are many. The plant only grows in certain restricted areas not easy of access, and the Makushi are careful to keep the habitat of the plant a secret. Fortune favoured me at last, for early in 1903 I one morning received a large parcel containing blowpipe arrows tipped with curare, branches and leaves of *S. toxifera* (Benth.), the gift of Mr. J. J. Quelch, the British Guianian traveller. The blowpipe arrows had been presented to Mr. Quelch by a Makushi chief as a special mark of favour, and Mr. Quelch had himself cut the plant, which had been pointed out to him by the *peaimen*, or makers of the poison, as the plant they employ in fabricating the arrow poison curare. This plant grows on the Urali Mountain of the Kanuku Range, British Guiana.

To follow up the proof. I examined the arrows and found them tipped with a substance which possessed the usual curare action on the motor end plates. I sent a portion of the branches and leaves to Mr. E. M. Holmes, botanical referee to the Pharmacopœia Committee, and he was able to say that they were those of *S. toxifera* (Benth.). I next examined the bark pharmacologically, and found it to possess the curare action on frogs. At the time I happened to have a large supply of excellent male frogs of a weight from 43 to 30 grammes, and these I employed to ascertain the smallest dose of bark which would completely paralyse the motor ends and without the animals recovering. The frogs were pithed, and the main artery of one leg was tied in the usual manner of such experiments. The following may be taken as a type of the whole.

An infusion of the dried bark having been made, the one ten-thousandth part of a gramme (15.432 grains) of bark was injected into the dorsal lymph sac of a frog of 43 grammes weight (663 grains).

In 20 minutes—signs of motor weakness.

In 50 minutes—greater signs of motor weakness, preceded by tetanic spasms.

In 80 minutes—the motor paralysis is complete and the protected limb alone is uplifted when the skin of the poisoned side is stimulated by pinching or the application of weak H_2SO_4 .

Passing on to 15 hours after injection—no signs of recovery from the motor paralysis.

In 24 hours there is a little recovery from the paralysis, but it is soon found to be only a temporary recovery.

In 40 hours the protected limb alone responds to stimulation of the skin of its own parts. Stimulation of the poisoned areas is not followed by uplifting of the protected leg. In connection with the question of paralysis of sensory ends by curare this should be noted also. Heart exposed and found beating. On strong stimulation of the sciatic nerve on the poisoned side the muscles below contract. This point will be touched upon later.

Further I made an extract from the bark, dried it in the sun and examined it on frogs, and as may be inferred it acted like the imported curare. It has been stated that the leaves of *S. toxifera* are bitter, but this is a mistake. They are not bitter, and they contain no curarine. Insects feed largely on them. The very tiny twigs of the plant likewise contain no curarine.

In case that I might happen to be mistaken I sent portions of the plant to Bancroft and Lacerda, and they have been able to confirm my results.

In continuation of the proof, I prepared from the bark pure curarine and found it to exist there in the proportion of 5.28 per cent., and it answered all the tests, chemical and pharmacological, of that alkaloid. Thus one may now say that the chain of evidence is complete, and we owe this to the perseverance of an English traveller, Mr. J. J. Quelch.

The other chief alkaloid of *S. toxifera* is curine, but it does not paralyse the motor end plates, and it does not at the present moment interest us. The minimum

paralysing dose of curarine for every gramme weight (15.432 grains) of frog (0.0000027 grammes) is about the 1-250,000th of a grain. In 24 hours the frog recovers from this dose. The frogs were pithed, I should add. Unless one had actual experience of the potency of curarine, it would hardly be believed that doses so small as those indicated above could have any action at all. Pure curarine in a thin layer is yellow, and it can be obtained in rosettes and plates; but it is highly deliquescent and soon deteriorates, and a second attempt at crystallisation is attended with failure. It is often asserted by authorities that the salts of curarine are inert, but this is wrong. I prepared a salicylate of curarine and kept it for weeks, and found it at the end of that time to be relatively as active as the absolute alkaloid. It may be mentioned that the alkaloid exists in the bark as a sulphate, which is no doubt easily broken up; then why should it not be possible to form active salts outside the plant? Pure curarine is readily decomposed by damp, and the greater the purity the more readily does it decompose and deteriorate. It is highly soluble, and cold water readily removes it from the bark, but this is in some respects a disadvantage, for the bark can with the greatest difficulty be exhausted. I found, on examining a bark which I had thought to be freed from curarine by percolation, that when it was infused and a portion injected into a frog, 0.032 gramme, or about half a grain, caused motor paralysis in a 22.5 gramme frog (347 grains).

I must briefly refer to one or two points, although they hardly come within the title of my paper.

1. Does curare affect the sensory ends?

Although the experiments of Tillie and others point to a non-affection, I hold the opposite view. If the dose of curare be large or if the experiment be so arranged or can be so arranged, that the poison acts sufficiently long it will be found that a stimulus applied to the poisoned skin area will fail to bring about uplifting of the protected limb, while a stimulus applied to the skin below the point of ligature will be followed by uplifting.

2. Is curare a tetaniser?

Undoubtedly it is, and the tetanus is not due to asphyxia. Curiously enough, it is often mixed because it is a transient sign and it is unsuspected. In the warm-blooded animals tetanus is more evident than in frogs, but in them death is rapid. In the frog the tetanising action of curare is best seen if the animal be not pithed and if the dose be very large—say, a large dose of curarine. The animal is not unlike one affected by strychnine, except that the tetanus appears to be more limited and that it soon passes off and gives place to motor paralysis. The tetanising action of curare was, so long ago as 1812, remarked upon by Waterton, and he writes of its action on fowls: "Three minutes generally elapse before convulsions come on." He experimented on larger animals, and in an ox the traveller found that "his legs were convulsed and his head from time to time started involuntarily. The startings or *subsultus tendinum* now gradually became weaker and weaker." This naturally leads us to another question—the relationship existing between the Asiatic *Strychnos* (as represented by *S. nuxvomica*) and the South American *Strychnos* (as represented by *S. toxifera*). At first sight it would appear that the difference is one of kind, but when examined more carefully the difference between them is discovered to be one of degree only; and this difference may be stated briefly as follows:—The Asiatic species (*S. nuxvomica*) is first and foremost a tetaniser and only secondarily is it a paralyser of the motor end plates; while the South American species (*S. toxifera*) is first most marked as a paralyser of the motor ends, and this is apt to mask the secondary tetanising action.

Practical Application.—Curare has been employed in the treatment of chorea, convulsions due to any cause in snake-bite and in strychnine poisoning, and to prevent painful spasm attending the transport of the wounded in warfare. The dose is from 1-20th to $\frac{1}{2}$ grain by injection. The percentage of curarine in commercial

curare is about 9 or 11, and some contain very much larger percentages. As much as 51 or 52 grains of curare have been injected under the skin at intervals of a period of time extending over 22 hours. Curarine is too uncertain a drug to employ because of its liability to deteriorate. To produce the typical curare action, very large doses must be given by the mouth, because the substance is rapidly eliminated by the kidneys. Curare is taken by the mouth by the natives of British Guiana as a bitter tonic. If we examine the manner in which curare acts in relieving spasm we find that if the spasm has a peripheral origin then we may look for benefit from its use, but if the spasm originates higher up than its employment is founded only upon empiricism.

I believe that curarine in large doses paralysed the sensory ends and that curarine is a tetaniser, but that the tetanus is of a short duration and apt to be overlooked unless carefully sought for.

Touching on the practical application of the plant and its preparation, I think they are not of much use. Passing next to the consideration of other substances resembling curare in action, I found that snake poison resembles it closely and also delphocurarine, an alkaloid derived from *Delphinium scopulorum*, a ranunculoid plant of Mexico. Ditamine (from dita bark) and alstonine (from Australian bitter bark) also possess something of the curare-like action on the motor nerve-ends, as well as aconite. The Moors in Spain employed extract of aconite to poison their arrows, and at the present day the Hairy AINU uses aconite as an arrow poison. The thorny yellow woods of Australia are like aconite in some ways in their action on the motor nerve-endings.

For some years past I have been experimenting with diphtheria toxin on pithed frogs, with the artery of one leg tied. The object was to ascertain if the toxin, in its action on the nervous tissue, first attacked the junction of muscle and nerve. I found that the poison acted slowly in frogs, enormous doses acting 24 to 40 hours only after injection, and in several of my experiments I have been able to show and to prove to my own satisfaction that perhaps the toxin first attacks the point of junction. I am continuing my experiments with diphtheria toxin and with several vegetable substances, which may possess curare action, and hope to publish results next year.

SOME CLINICAL OBSERVATIONS ON NEW REMEDIES. (a)

By NESTOR TIRARD, M.D.,

Lecturer on Medicine, King's College Hospital.

AFTER some introductory remarks the lecturer said uricidine, or lithium citrate, with lemon juice and soda, had been recommended for gout; uric acid concretions, and rheumatism. Really it chiefly acted as a laxative and did not relieve the pain of gout nor dissolve uric acid concretions. Its dose was 1 to 2 drachms.

Urotropine, made from formaldehyde and ammonia, was said to be a diuretic which relieves cystitis owing to uric acid concretion and destroys typhoid bacilli in urine, but unless well diluted it may cause hæmaturia and sometimes strangury, albuminuria and abdominal pain, but these bad symptoms do not occur if each dose is diluted with 5 ounces of water. In cases of offensive urine with uric acid sand he found it remove the offensive smell and diminish the sand. Dose 5 to 15 grains.

Aspirin, or acetylsalicylic acid, is not better than salicylic acid, and often produces dyspepsia and profuse perspiration, sometimes diarrhoea. In headache from overwork in gouty persons it often relieves the pain and causes sleep, but the patient should remain in bed after taking a dose, because of the perspiration.

Dose 10 grains in compressed form, as it is very insoluble.

Mesotan, or mesoxyl ester of salicylic acid, is readily absorbed by the skin when applied with olive oil. It relieves the pain and stiffness of rheumatism when fever ceases. Sometimes it irritates the skin if rubbed on it, or if covered too thickly, or if mixed with water. It should be well diluted with olive oil and painted on with a brush.

Ovoferrin, made by heating iron torpate with serum albumen, increases the hæmoglobin. In a case of pernicious anæmia its use with 15 minims of liquor arsenicalis thrice daily increased the hæmoglobin 64 per cent. It must not be diluted till taken, or it may decompose.

THE COMPARATIVE VALUATION OF DISINFECTANTS.

By C. G. MOOR, M.A. Cantab., F.I.C.

SOME months ago (May 11th, 1904) the question was discussed in your columns as to the relative values of disinfectants, and being greatly interested in the subject I had hoped you would have published the results of the investigations you then proposed taking; but probably you have found the task to be herculean.

It is evident, however, from the many references thereto in the medical and analytical journals, that the question of the comparative efficiency of disinfectants is receiving considerable attention among medical men and sanitary authorities.

Comparisons of this character have been attempted with more or less success ever since we were in possession of pure cultures of pathogenic bacteria to work upon. Unfortunately, the various small details which must be closely observed in order to ensure success have only been discovered comparatively recently, and most of the results recorded in text-books must be accepted with great caution. The method published by Dr. Rideal and Mr. Ainslie Walker in the *Journal of the Sanitary Institute*, Vol. xxiv, Part III, embodies the details necessary for success, and has virtually been accepted as the standard process both by British workers and those on the Continent. This process consists in submitting cultures of any pathogenic organism to the action of precise dilutions of the disinfectant under specified conditions, at the same time running comparative tests with dilutions of pure phenol on similar cultures of the same strains of bacteria. In this way actual numerical valuations can be obtained in terms of phenol. This method was employed by the referees appointed by the German Court in a recent case in which Mr. Pearson, of Hamburg, took action against the Jeyes Sanitary Compounds Company, in respect to their claim to have discovered a disinfectant four times as strong as the product they had previously been supplying to Germany (and elsewhere) under the name of Creolin. They claimed that their new preparation, sold under the name Cyllin, was four times as strong as Creolin, and eleven times as strong as pure carbolic acid. The case was tried in the District Court at Hamburg, and the decision given in favour of Messrs. Jeyes, whose claim on behalf of Cyllin was thereupon upheld.

A further development of the practical utility of an exact standard method for the valuation of disinfectants is well illustrated by the new form of tender for disinfectants which (*Chemist and Druggist*, December 10th, 1904) is likely to be issued by the Borough of Chelsea, in which they invite tenders for so much "carbolic acid, or its germicidal equivalent."

As an illustration, if any manufacturer were able to produce a disinfectant having five times the efficiency of carbolic acid, he could tender 200 gallons of his particular make as an equivalent of 1,000 gallons of carbolic acid, and assuming that the proprietary article cost 2s. 6d. per gallon and the carbolic acid cost 1s. 6d. per gallon, the saving to hospitals or to the ratepayers would be exactly £50.

(a) Abstract of Paper read before the Therapeutical Society, Tuesday, December 26th, 1904.

This is a new departure of great importance, and while it will certainly save to the ratepayers, it will also ensure their having a disinfectant of real utility. Several of the better known disinfectant manufacturers have already succeeded in producing an article which is *strength for strength* decidedly cheaper than carbolic acid, and has the advantage of forming good emulsions with water. In addition the healthy competition that such a tender-form will create among manufacturers cannot fail to stimulate them to produce as efficient a disinfectant as possible; will make for the general good, and the terms of the tender will also make it impossible for any suspicion of undue influence to attach to any public official owing to his having considered it his duty to recommend his authority to purchase either this or the other preparation.

ALCOHOL

AS A FACTOR IN THE CAUSATION OF DETERIORATION IN THE INDIVIDUAL AND THE RACE. (a)

By W. McADAM ECCLES, M.S., F.R.C.S.,
Assistant Surgeon to St. Bartholomew's Hospital.

MR. ECCLES offered no apology for bringing forward again a matter of individual and national importance. As one of the witnesses before the Inter-Departmental Committee on Physical Deterioration, he had paid special attention to alcohol as a factor in producing such deterioration. In the term "alcohol" he would include all varieties of alcohol, and also the still more poisonous substances contained in many alcoholic beverages. By "deterioration" he understood a decline in the economic value of the organism produced by an actual change in cell constitution. It should be distinguished from "degeneration," which was rather a decline from morals, and the two conditions contrasted much in the same way as an objective sign did with a subjective symptom. The direct alteration in a cell might be demonstrated microscopically, and that produced by alcohol had been repeatedly so demonstrated. Alcohol acted in bringing about deterioration. This was almost universally admitted. It acted both directly and indirectly.

Direct action upon the individual varied enormously, and this on account of the personal equation of the subject. This personal equation obtruded itself in the way of age, environment, occupation, a nervous instability, and actual disease. Probably the younger the cells infused with alcohol the greater the harm impressed upon them. Hence the growing tissues of children were quickly deteriorated. He considered it probable that many instances of rickets occurring in children who were breast-fed were due to insufficient and abnormal mother's milk charged with small but repeated doses of alcohol. In old age alcohol was a potent factor in rapidly wearing out the human machine. The environment had a great influence upon the effects of alcohol in causing deterioration. The close connection between a craving for drink and bad housing, bad feeding, a polluted and depressing atmosphere, long hours of work in over-heated and often ill-ventilated rooms, only relieved by the excitements of town life, was only too self-evident, and the ravages of alcohol under such circumstances only too perceptible on all hands. It was just in these very factors of deterioration that a vicious

circle was apt to be set up. Bad housing and bad feeding created a desire for alcohol, and the money spent on the drug left less for rent and proper comestibles. The meagre knowledge of cookery possessed by young women brought up in towns led to much inducement for both their husbands and themselves to frequent the public-house for the purpose of obtaining alcohol to give them the sense of having secured a good meal. Want of fresh air deprived the drinker of the oxygen needed for the destruction of alcohol. Fatigue and excitement both engendered a thirst for alcohol, and through it deterioration. In connection with occupation it appeared that the higher and more intricate the character of the work undertaken by a man, the more rapid were the deteriorating effects of alcohol upon him. The drudgery of many female lives made women have recourse to alcohol. The fact of deterioration by alcohol was abundantly proved by the statistics of those life assurance offices which separated the "lives" of moderate drinkers from those of total abstainers, the greater longevity of the latter being distinctly marked. The indirect action of alcohol in the production of deterioration was even more pronounced than the direct, and was particularly so upon child-life. Both before and after the birth of the infant, alcohol in the mother told upon it. Whatever view might be held with regard to heredity, there could be but little dispute that the alcoholic mother neglected her offspring, and that the effects of such neglect were disastrous. If the mother as well as the father were given to alcohol, the progeny would deteriorate in every way, and the future of the race would be imperilled. The facts deduced to show that alcohol caused deterioration were worthy of close consideration with a view to the eradication of a force tending to undermine the efficiency of the nation.

Lunacy Department.

ASYLUM REPORTS.

Glasgow District Asylum, Woodilee.—During the year the number of patients under care and treatment was 1,177; the admissions numbered 292—162 males and 130 females. The number of patients discharged recovered was 138, while 72 patients were discharged "not recovered", the deaths numbered 86—57 men and 29 women. In 31.8 per cent. of the patients admitted there was a history where alcoholic excess played the chief part in the causation of insanity. Insanity as the result of venereal disease occurred in 21 cases, while general paralysis was the form of insanity found in 33 admissions—29 men and 4 women, and was the cause of death in 22.7 per cent. of all the deaths that occurred among the male patients of the asylum during the statistical year. Dr. Marr thinks the reason why the history of venereal disease does not occur in the clinical experience of all such cases is that many of these cases, before reaching an asylum, have migrated from one hospital to another, and the clinical symptoms of the disease have disappeared in course of time, or as the result of desultory treatment, since such patients do not often submit to the lengthened period of treatment required by the medical authorities. In short, he says, given venereal disease, the vices that attend residence in

(a) Abstract of a Paper introductory to a discussion at the Society for the Study of Insanity held in the rooms of the Medical Society of London, 11 Chandos Street, W., on Tuesday, January 10th, 1905.

a large urban community are sufficient, if indulged in, to incite this fatal form of nervous degeneration. We still, however, believe that there are cases of general paralysis of the insane, where venereal disease has never existed, and we think that in this and certain other asylums too much is made of this and also alcoholic excess as a cause of insanity. The percentage of recoveries, calculated on the number of admissions, was 47.2. This is the largest recovery-rate recorded for twenty years. One thing which deserves most favourable notice at this asylum is the reception house. Since the opening 373 patients have been admitted to its wards, and of this number 130 have been discharged recovered, without having to mix with patients in the main asylum. An excellent new laboratory for clinical and pathological work has been opened. It is provided with rooms for microscopical, bacteriological and chemical investigation. In addition, there are mortuary and *post-mortem* room, accommodation for special research work, a room for photographic purposes, and a museum and library for the medical staff. We cannot, however, but think that such an elaborate laboratory much exceeds the requirements of a district asylum, especially in Scotland, where all the asylums can utilise the Scottish Asylums' Laboratory. From the small amount of original work done in the past by asylum pathologists, and as they are frequently only birds of passage, only waiting for a better appointment owing to the small remuneration asylums can afford to pay them, we think much better and more useful pathological work could be done by each asylum pathologist working under the guidance of the director of a central laboratory such as Scotland now has. A nurses' home, which will accommodate 110 nurses, has been opened, and much progress has been made in the training of nurses in this asylum. The nurses require to pass an educational examination during a probationary period of three months. After three months' training they must show evidence of the sufficiency of their training by passing examinations necessary for registration as nurses with the Local Government Board, and for obtaining the certificate of the Medico-Psychological Association. On the strength of this evidence, nurses will be admitted to one of the district hospitals of Glasgow Parish Council for a further period of training for one year. This we consider a most excellent arrangement. Much interesting reading will be found in this report, which is well illustrated, and throughout there is marked evidence of progressive and scientific management.

Transactions of Societies.

NORTH-EAST LONDON CLINICAL SOCIETY.
MEETING HELD THURSDAY, JANUARY 5TH, 1904.

DR. R. MURRAY LESLIE, President, in the Chair.

DR. A. J. WHITING opened a discussion on THE MEDICO-LEGAL ASPECTS OF ALCOHOLISM. The speaker held that, from the medico-legal standpoint, alcohol was only of interest when it was taken in sufficient quantities to exert a poisonous action, although chronic alcoholism might have some forensic importance, as, for example, in affecting the memory or the truthfulness of a witness, yet the chief interest centred around acute alcoholism, especially in the matter of

diagnosis. This might be conveniently divided into two stages, the *pre-* and the *post-comatose*. The only pathological conditions which might be confused with the pre-comatose stage of acute alcoholism were post-epileptic automatism, from its apparent irresponsibility of conduct, locomotor ataxy, from its staggering gait, and general paralysis, from its articulation, incoherence, and grandiose ideas.

It was after the onset of coma that the real difficulties in diagnosis began, and medico-legally, this was the most important practical part of the subject. The importance of a correct diagnosis was clearly shown by those instances, of not very frequent occurrence, in which persons have been considered by the police to be suffering from drunkenness, and have been left in the cells to "sleep it off," with the result that they were found later to be dying from some other condition. The pathological states which might simulate profound alcoholic intoxication were then classified thus:— (1) Coma from toxic doses of some medicinal agent, such as opium, belladonna, carbolic acid, &c.; (2) coma from poisons other than drugs, such as in uræmia, diabetes, and asphyxia from poisonous gases; (3) coma following convulsions; and (4) that resulting from some cerebral lesion, whether minute or gross. Before a logical diagnosis could be arrived at, three difficulties had to be faced: (1) no history of the patient's previous health was usually obtainable; (2) alcohol was frequently administered by sympathetic onlookers, so that the odour of alcohol in the breath was of little value; (3) two or more conditions might be combined in the same individual. A differential diagnosis was then given of acute alcoholism from other conditions, special stress being laid upon the pupillary symptoms, the depth of the stupor, the temperature, the presence of paralysis, and the question of external injuries.

The PRESIDENT referred to the bearing of chronic alcoholism upon such matters as the validity of wills, and to the necessity of the enforced treatment of chronic inebriates in institutions.

DR. C. R. SALISBURY alluded to the moral deviations in regard to truthfulness which was such a frequent symptom in chronic alcoholism.

DR. J. W. HUNT advocated caution in a medical man committing himself to a diagnosis in doubtful cases of unconsciousness, and he remarked upon the wisdom of acting as if such were all serious cases. He thought that in 30 per cent. of the cases of cerebral hæmorrhage in his experience the onset was not sudden.

DR. R. F. TOMLIN described a case of double pneumonia in which there were automatic actions simulating those following upon an epileptic attack.

DR. T. D. MANNING especially alluded to the circulatory changes in the various sorts of intoxication.

DR. H. F. STAUNTON thought that, as a rule, the coma in a surgical case was not so deep as in a toxic case.

DR. A. E. GILES referred to the occasional difficulty of diagnosing between the lesser degrees of alcoholism and the earlier stages of mania.

MR. HERBERT CARSON emphasised the difficulty of diagnosing between acute alcoholism and cerebral compression following head injuries, especially fractured base; it was not so great in cases of simple concussion. He also insisted upon the possibility of the presence of a subdural hæmorrhage of traumatic origin without any external wound.

DR. WHITING, in replying, thought that it was necessary to weigh all the facts in any individual case, and not to trust to any one symptom or sign.

ULSTER MEDICAL SOCIETY.

MEETING HELD ON THURSDAY, JANUARY 5TH, IN THE MEDICAL INSTITUTE, BELFAST.

The President, DR. WILLIAM CALWELL, in the Chair.

PROFESSOR SIMS WOODHEAD, of Cambridge (who had come at the invitation of the Ulster Branch of the

British Medical Temperance Association), opened a discussion on the subject of

ALCOHOL AS A PROTOPLASMIC POISON.

Dr. WOODHEAD, who received a very hearty greeting from the Society, began by giving his reasons for considering alcohol to be such a poison, doing harm of necessity. He contended that experiment showed that the general action of alcohol on protoplasm was harmful, and the more highly organised the protoplasm was the more harmful the alcohol proved to be. That the action of alcohol was gradual was shown by the gradual extinction of the light of phosphorescent bacilli, whose functional activity is interfered with by a 2 per cent. solution of alcohol, and destroyed by a 6 per cent. Fatty degeneration was produced by small doses of alcohol on more highly-developed, and specially on young, protoplasm. There are marked resemblances to phosphorus poisoning. It was best seen in the liver, but exactly the same process took place in the heart, the degeneration being in proportion to the amount of toxic material. This degeneration is found in the heart at the termination of the peripheral vessels. Dr. Woodhead maintains that alcohol must be looked on as a cumulative protoplasmic poison, and it acts on the heart in the same way as many diseases do, and therefore must increase the result brought about by them, if given during their progress. We are perhaps inclined to pay too much attention to the higher cells, and not sufficient to other tissues, in which the same changes are probably going on, as, for instance, the changes in the connective tissue of the blood-vessels. Wherever we have degeneration in higher tissues we get calcification, and Dr. Woodhead held that the same form of degeneration in blood-vessels was often due to alcohol. After referring to the use of alcohol in various diseases, Dr. Woodhead dwelt on its peculiar action in lead poisoning, which is greatly facilitated by its presence in the organism, abstainers being seldom attacked. He then discussed immunity and alcohol. In five diseases in which immunity is clearly produced in the course of the disease, namely, anthrax, hydrophobia, tuberculosis, diphtheria and tetanus, alcohol markedly interferes with the production of immunity, so that it is difficult or impossible to produce when alcohol is being given. He concluded, therefore, that in those diseases alcohol must as a rule do harm.

Professor BYERS said that many of the scientific points we were not in a position to discuss, but practitioners might well consider how far the views set forth agreed with the facts as observed in practice. He pointed out the extraordinary change in recent years as regards the use of alcohol in pneumonia, puerperal fever, and after operation.

Professor LINDSAY was not in complete assent with Dr. Woodhead. He thought in the revulsion of feeling against the over-use of alcohol the pendulum might swing too far the other way. He thought alcohol was not a necessity, that the proportion of people who could abstain with advantage was probably a large one, and that there was no disease where alcohol was indicated as a routine medicine. But he was doubtful about applying laboratory experimental calculations to clinical work. Clinically he was very sparing in its use, but he believed that in some cases, with weak circulation, and in some nervous conditions with sleeplessness, alcohol was a valuable remedy. Also he used it in some cases as a tonic, but on the whole he thought we might more profitably dwell on its dangers than on its uses.

Dr. KEVIN referred to the increase of insanity, and its connection with alcoholism.

Professor MILROY discussed some of the experiments mentioned by Professor Woodhead, and thought that alcohol should be classed as a narcotic poison.

Dr. JOHN CAMPBELL considered the views of Dr. Woodhead on the whole correct, but there were two sets of cases where he thought it might be used with advantage, first, in hopeless cancer cases, where it helped the action of morphia, and secondly, in septic

infection, where small doses often overcame restlessness even better than morphia.

Dr. ROBB said that he had treated about 3,000 cases of typhoid fever in the last four years, and he did not think he used alcohol in 5 per cent. of them. In those few cases, however, he was not inclined to give it up, as he thought it was occasionally very useful. He had about 100 diphtheria cases a year, and alcohol was practically never used in them.

Dr. MITCHELL discussed the withdrawal of alcohol in cases of accident to alcoholic patients, which he thought dangerous.

Dr. BURNS and Dr. KILLEN having also spoken, the President wound up the discussion with a few remarks on the use of alcohol by the aged, which he did not think at all so necessary as some previous speakers.

Professor WOODHEAD having replied, a hearty vote of thanks to him for his visit was passed on the motion of Professor SYMINGTON, seconded by Dr. JOHN CAMPBELL.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, JANUARY 8th, 1905.

THE TROUBLES OF THE WISDOM TOOTH.

THE wisdom tooth develops generally between the ages of sixteen and twenty-five, and in some cases much later, at forty, fifty, or even sixty years. Numerous are the troubles caused by it, more frequently observed in the male sex, also seeming to have a certain preference for the left side, says Professor Morestin. The teeth of the lower jaw alone are affected; the wisdom teeth of the upper jaw never give rise to any accident.

The molar is found in the body of the maxillary bone covered by a thin osseous coating and ready to take its place in the mouth. This it does by pushing forwards the second large molar, and as the space between that tooth and the ascending branch of the maxilla is very limited, it has to work its way up by curving now to the right, now to the left, until it pierces the gum and finally establishes itself. If matters pass quietly the individual will suffer but slight pain; the gum may be a little swollen, and a little fever may be observed. But in the majority of cases these symptoms are but the commencement of grave troubles; the gum becomes more and more painful, because the upper wisdom tooth, which is always the first formed, presses on it each time the mouth is shut, or during mastication. If infection set in the phenomena become greatly aggravated; the temperature runs high, and the general symptoms mark the intensity of the lesions, or the pus invades the socket, and very tenacious dental arthritis is the result, or by the two small conduits which united the roots of the tooth to the dental canal, creating osteo-myelitis of the maxilla—a very grave affection; or it attacks the muscles, producing myositis of the pterygoid muscle, giving rise to contraction or trismus of a more or less permanent character. Sometimes the pus invades the mouth or the pharynx, producing a phlegmon, which may provoke suffocation or asphyxia. The osseous lesions suppurate for a very long time, and in the case of osteo-myelitis, for instance, necrosis of the bone may result, followed by perforation of the cheek. But all these accidents, however grave, are out-distanced by lesion of the venous plexus of the region; here thrombosis of the veins may produce an abscess of the brain, meningitis, and death. Consequently active treatment is called for in cases of painful cutting of the wisdom teeth. If the symptoms are slight and only due to tension of the inflamed gum, it will be sufficient to apply the thermo-cautery or incise the gum with a lancet. If, on the contrary, there already exist evident signs of dental arthritis, the tooth must be immediately extracted, otherwise some of the above accidents may occur. According to Professor Morestin, sufficient attention is not paid to development of the wisdom

tooth, as in many cases the sufferings of the patient are attributed to some other cause, such as neuritis, rheumatism, &c.

THE TREATMENT OF OZENA.

The treatment of this very troublesome affection has given rise to many therapeutic combinations, which, being tried, were found to be more or less wanting: camphor, iodoform, formol, thymol, menthol, &c., were recommended and are still used, but a permanent cure is difficult to obtain, many factors entering into the nature of the affection.

Dr. Bobone claims to have obtained great success with the use of petroleum, which he considers in the dual point of view as a bactericide and a stimulant.

The solution he uses is as follows:—

- Refined petroleum, 1½ oz.;
- Nitrate of strychnine, ¼ gr.;
- Oil of eucalyptus, 1 drop;

After antiseptic irrigation of the nasal cavities to remove all secretion, a piece of cotton wool steeped in the solution is applied by means of a stylet to all the surface of the fossæ once a day. In a short time all offensive odour disappears, and the mucous lining assumes a healthy appearance.

Another effective treatment consists in insufflation of the following powder:—

- Collargol, 10 grs.;
- Sugar of milk, 3 drs.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, January 7th, 1905.

At the Gesellschaft der Aerzte, Hr. Orth spoke on EMPHYSEMA OF THE LUNGS.

He said that in the rare cases in which the disease occurred in infants, it was not inherited (congenital) as there was no breathing during intra-uterine life. But there was an inherited disposition that could lead to emphysema after birth, and this was perhaps to be explained by a change in the elastic properties of the lung. Air pressure, especially the expiratory, played a part in the origination. Inspiratory effort could only act in this way when it was freed. As regarded the expiratory pressure, it was to be said that it could only act on the part not subjected to pressure. Observation on trumpeters showed that expiration alone could not cause emphysema, as they were not all asthmatics: a disposition to it must be added. There was also a partial emphysema.

Hr. Heubner asked whether the rigid thorax observed in infants and later was due to emphysema, or the other way about. Hr. Orth thought the changes in the lungs were primary.

Hr. Lesser mentioned the relationship between eczema and asthma.

At the Laryngological Society, Hr. Peyser related a case of

COCAINE POISONING.

A girl, æt. 18, had taken a gramme of cocaine hydrochlorate. The first serious symptom showed in an hour and three-quarters: sleepiness, very frequent pulse, complete dilatation of the pupils, clonic spasms of the extremities, opisthotonos, protrusion of the tongue, &c. The stomach was washed out and a hot bath given, with cold douches. Eight grammes of nitrite of amyl appeared to have a favourable effect. A state of excitement lasted for a longer period than the other symptoms.

At the Medical Society the subject of MAMMARY CANCER

was introduced by Hr. Lassar. He showed a patient with a cancerous ulcer that had arisen after operation for recurrence, and that would not heal. After the X-rays had been applied a smooth cicatrix formed in a short time. He thought the X-rays were particularly useful in these ichorous ulcers that would not heal. They also came into consideration for the superficial tumours lying in the skin; but no result need be expected in the case of deeply lying carcinomata. The treatment should not come into

rivalry with ordinary procedures, but it might be useful in cases of inoperable mammary cancer.

Exc. v. Bergmann showed three women with mammary cancer of unusual form: (a) one with enormous dissemination in the skin, so that small nodules could be seen, or better still, felt, even down to the lumbar region; (b) extraordinarily marked infection of the lymph vessels of the chest, neck and upper arm; (c) one similar to the foregoing, and also a board-like hard infiltration in the neck, which was diffuse, not knotty, and gave rather the impression of a deep phlegmon.

Hr. Blaschko spoke on

SYPHILIS AS A PROFESSIONAL DISEASE.

He said he had had to treat twelve medical men suffering from syphilis contracted in the course of their calling. Most of the primary effects were on the fingers, and they had been treated as whitlows, until the torpid appearance and glandular swellings and exanthem had pointed to the true character of the disease. Once the primary disease was on the face, which had been scratched before the infecting material came into contact. In many cases the primary disease on the hand was very small, and it healed very rapidly; in one case there was no primary affection, so there must be a syphilis without primary disease, the infection material passing directly into the blood; an insect bite might possibly aid infection.

Infection of medical men took place in two ways: (a) from operation in syphilitic tissue such as buboes; (b) from contact with a sore already present. One case was that of a pathologist who had dissected a body covered with a syphilitic exanthem within twenty-four hours of death. There was no absolute protection. The surgeon should perform every operation and make every gynecological examination, as if the patient were syphilitic. Vaginal injection should be made, and in suspicious cases a finger stall should be used. The smallest wound should be looked after. Many of them were the consequences of too vigorous scrubbing with brushes and disinfectants. If the skin was delicate disinfection might be limited to washing with hot water and marble soap. If thorough washing were performed after touching suspicious material, our hands would not be so readily bearers of infection, even if excessive disinfection was not resorted to before the contact. Rubber gloves also might be used.

If rhagades were present they should be bathed with a 2 or 3 per cent. nitrate of silver solution and then sticking plaster or collodion put on. If with every care a wound was infected during operation, it should be flushed with water and dabbed with iodide or peroxide of hydrogen, or cauterised with the thermo-cautery.

The pessimistic conception of this disease led many surgeons, especially in their earlier years, to a too frequent course of mercury. This was not proper; he would use mercury only where disease was present; he was therefore opposed to the chronic intermittent administration of mercury in the first years of the disease.

The twelve cases were not particularly severe. It was not true that cases of extra-genital infection were specially severe.

Regarding the question as to how long a surgeon should refrain from work, naturally he must do so so long as the diseased part was capable of causing infection. In intervals free from recurrence, even if the mucous surface were diseased, nothing stood in the way of his following his employment.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, January 7th, 1905.

LYMPHANGIOMA CAVERNOSUM WITH CHYLORRHEA. At the Gesellschaft, Paul Albrecht demonstrated a case of lymphangioma cavernosum with chylorrhœa. The swelling had commenced some six years ago

over the right femur, extending into the groin. The surface was white and soft, and over the surface of the greatest prominence there were large vesicles averaging about the size of a pea, which emitted a clear fluid. If the patient took fatty food fleshy warts appeared on the surface, in the centre of which yellow colouring matter was observed. Tests with sesami oleum and alkanna root failed to demonstrate its chylous nature, but the presence of sugar, fat, and albumen gave undeniable proof of its presence. Within the last two weeks a similar swelling has commenced in the left groin. Neumann reminded the members of a similar case that he had exhibited to them two years ago. In that case he administered different colouring matters by the mouth, which acted on the lymph, giving a similar hue one and a half hour after. Albrecht's case differs in this respect, as he seems to have failed to obtain this colouring in the lymph. In my own case it may be remembered that Eiselberg extirpated the white swelling, and found the entering lymphatic vessels as large as goose quills. Franck said he had a young man some time ago who came to him with prominent lymphatic varicose ducts in the right leg, extending from the foot to the groin. Where the varix was present, when opened it was found to contain a small quantity of milky fluid. Eiselberg said that he had now seen two cases of lymphangioma with a considerable discharge of milky fluid. The therapy of this disease does not seem to meet with much success, but the earliest and most reasonable to recommend is the Paquelin treatment.

Weinlechner briefly recounted the history of a case that came under his own observation in the form of a large cyst which extended from the arm-pit to the pelvic bones.

Riehl next entered into the pathology of the disease and described the origin of the morbid changes as a malformation, probably hereditary, in the position of the lymphatic vessels, or in other words a lymphatic nœvus, which commences at first in a small area, and extends along the endothelium increasing the lymphatic vessel until a cyst is finally produced.

The history of the case before us admits of this interpretation: commencing six years ago, it gradually increased, and invaded the neighbouring structures, until the whole leg was involved with cystic formation of chylous matter. The chylorrhœa in this case is more prominently demonstrated by the inguinal lymphatic vessels of the left side of the pelvis becoming involved from the same anomaly in the anatomy as existed in the right side. Albrecht pointed out the difficulty of accepting the theory of a lymphatic nœvus by repeating the patient's history, that the cystic tumour in the left inguinal region was only discovered a few weeks ago, and that the skin covering the cyst was found to be in a normal condition.

SPINAL ANALGESIA.

Silbermark commenced his promised lecture on 200 cases in which he had operated with the assistance of this new spinal analgesic, for some time practised, in Mosetig's wards. After a careful description of the *technique* to avoid failure, he said cocaine must not be used, but "eukainia," or best of all "eukainiss," should be administered. A 3 per cent. solution, and freshly made, should be injected in doses of 10 cubic centimetres at a time. If the patient be under 16 years of age two centimetres of the 3 per cent. solution may be enough. If the solution be three days old the power and duration of the analgesic effect is greatly reduced; in this case the dose would have to be correspondingly increased. In this way Silbermark had given very large doses without any bad effects. The duration of the analgesia lasts from five minutes to one and three-quarter hour. Position has much to do with the modification of time, as the perinæum and genital organs never exceed five minutes. The loss of sensation commences in the following order:—1, pinching or nipping; 2, stabbing or pricking; 3, loss of temperature sensation; and 4, finally all clinical irritation.

The analgesic limit in the trunk seems to be across the umbilicus. A drawing of the perinæum in imperfect cases gives the patient a feeling of pressure; although a cut may be felt as a cut, or a tear as real, no pain is associated with the act. The sensation returns first at the point of the toes, next across the line of the umbilicus, and lastly in the peritonæum. No toxic symptoms such as bulbar irritation were witnessed, although muscular quivering has been observed, which at once disqualifies the patient for such a method of operation—in this case chloroform should be resorted to, and a few drops are quite sufficient to produce anæsthesia. Any age between 11 and 69 years may be put under this method, the younger being affected more rapidly and more frequently with vomiting and muscular twitching, with transitory collapse, relieved by raising the pelvis, although the opposite is often effectual; alcoholics are usually the most difficult. After the operation no headache or untoward symptom has been observed, neither is the pain in the wound more painful than under chloroform. Retention of urine never exceeds three days when it does occur; post-operative temperature 38° Cent., and feeling quite well in two or three days.

The eucaïne treatment is contraindicated under ten years of age; relatively dangerous between 11 and 16, as well as in the alcoholic. Tabes, arteriosclerosis, and allied conditions are well adapted for this method of operating. When vomiting does occur the danger is *nil*, as the functions of the body are little disturbed; hence he concludes that spinal anæsthesia is the best.

The Operating Theatres.

ROYAL EAR HOSPITAL.

RADICAL MASTOID OPERATION.—Mr. MACLEOD YEARSLEY operated on a girl, at 14, who had been sent up to the hospital by Dr. Biggs, of Battersea. The history of the case was as follows:—Eight years ago she had a sudden acute attack of right middle ear suppuration. Her mastoid was opened at St. Thomas's Hospital, and a portion of the right internal jugular vein removed. This treatment appears to have had a satisfactory result until three years ago, when, during the course of a cold in the head—to which she was very subject—a foul discharge appeared, and has continued ever since, with occasional attacks of pain. On examination, a large semicircular scar was found over the mastoid process, and a three-inch cicatrix at the lower part of the neck along the anterior border of the sterno-mastoid. The membrana tympani was the seat of a large posterior perforation, and granulations could be seen through it within the tympanum. Both tonsils were considerably enlarged, and there was a pad of adenoids in the naso-pharynx. The patient was placed under chloroform and an incision made through the original scar over the mastoid, the auricle with the membranous meatus turned forwards, and retracted by a strip of gauze passed through the meatus. On detaching the periosteum a hole about the size of a sixpence was seen in the bone, its edges to a certain extent rounded by repair. This led into the antrum, which was full of flabby granulations and *débris*; the bridge of bone between this hole and the meatus was removed with the chisel and gouge, the remains of the membrane with the malleus and incus were cleared away, and the whole antrum, attic and tympanum thrown into one cavity. It was then found that the facial nerve was bare for a part of its course in the Fallopian aqueduct. The granulations which filled the antrum and tympanum were curetted, and especial care taken to thoroughly curette the

entrance to the Eustachian tube. A square flap was then cut from the upper and back part of the cartilaginous meatus, the cavity was carefully dried and packed with iodoform gauze, the auricle readjusted, and the wound sutured in its entirety. Mr. Yearsley said that this case was evidently one in which the radical operation would have probably been the wisest course when the mastoid was first opened, but it must be remembered that the time-honoured Schwartz operation was the only one known to general surgeons until quite recently. It must, however, be borne in mind, he thought, that in cases of acute mastoid suppuration, especially when uncomplicated, simple opening of the mastoid sufficed in the majority of cases; this case, however, was evidently complicated with some phlebitis of the internal jugular vein, for part of that structure had been explored at the original operation; at the same time it was interesting to note that no signs had been found at the present time of any implication, recent or remote, of the lateral sinus. It would be noted, he remarked, that there was a clear history of adenoid growths. It was possible that these were originally responsible for the ear disease, and it was surprising that, after opening the mastoid, the original operator had not thought fit to remove them; had he done so the tendency to frequent colds exhibited by the patient, which no doubt led to the recrudescence of the discharge, might have been prevented. In that case simple opening of the mastoid might have been sufficient, and the patient need never have come to the operating table again.

The adenoids and tonsils, he said, would be removed under gas during the following week.

TOTTENHAM HOSPITAL.

OPERATION FOR INTESTINAL OBSTRUCTION IN A WOMAN OF ADVANCED AGE with an interesting history.—Mr. H. W. CARSON operated on a woman, æt. 79, who had been admitted with the following history:—Fifteen years ago she had had her right breast removed for scirrhous carcinoma; this was followed by two recurrences, both of which were successfully operated on by removal. She remained in good health until four months ago, when she was admitted to the hospital with strangulated femoral hernia on the left side. At the operation for this condition the sac was found to contain a Meckel's diverticulum. She remained in good health for a month, when she was once more admitted, this time under Mr. Carson, and with intestinal obstruction. A definite tumour could then be felt in the left iliac fossa. Laparotomy was performed, and the cause of obstruction proved to be a malignant growth of the descending colon; the growth was fixed outside the abdomen, and the proximal part of the intestine drained by a Paul's tube. Ten days after, the growth was excised and the divided ends of the colon joined by end-to-end anastomosis. This was followed by an interval of six weeks' comparative comfort; she was then once more admitted with intestinal obstruction. Nothing could be felt in the abdomen except a great deal of resistance and some definite hardness underneath the left rectus abdominis. Frequent vomiting was a marked feature of the onset at the present operation. The abdomen was opened, and it was found that the lower part of the ileum was fixed by adhesions resulting from the previous operations, and that for seven inches the lumen was entirely obstructed. The adherent portion was rapidly freed, but owing to its

stenosed condition it was found necessary to excise it, and seven inches of the intestine were removed, and the ileum re-united by end-to-end anastomosis, a Murphy's button being used. Mr. Carson said that the interest of the case lay in the recurrence of malignant disease so many years after the removal of the initial lesion. It was difficult to say whether it was a case of recurrent carcinoma or whether it was an entirely new manifestation. The course of the operation for removal of the intestinal growth gave an opportunity of enforcing the necessity, in cases of obstruction associated with distension above the stricture by faecal accumulation and gas, of preliminary drainage before an attempt is made to remove the growth by resection. In the present operation distension above the obstruction was so slight, and the necessity of saving a patient of such advanced years the risk of a second operation, influenced him in the course he adopted of immediate enterectomy and anastomosis. He remarked that although as a rule he much preferred to do end-to-end anastomosis by simple suture, he chose Murphy's button in this case with a view to reducing the length of operation as far as possible. He drew attention to the extraordinary vitality shown by this patient, who, at the age of seventy-nine, had undergone three severe abdominal operations within four months.

The patient passed the button on the fifteenth day, and made an uninterrupted recovery.

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The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, JANUARY 11, 1905.

THE HOSPITAL, THE HOSPITAL FUNDS, AND THE ROYAL ORTHOPÆDIC HOSPITAL.

In the *Hospital* for December 31st, the editor considerably inquired if we knew the laws of the constitution of the Hospital Sunday Fund. It was with a precise knowledge of the representative character of that body that we wrote. It is true that the Council consists of fifty clerical or lay members in addition to the committee of

distribution and officers who are members by virtue of their position. Among the fifty members, however, we fail to find the name of any single representative of the small hospitals. The large hospitals, on the other hand, are abundantly represented by chairmen and other honorary officials, and by members of their medical staffs. The Council, thus constituted, confirms the report of the Distribution Committee, which is the real controlling power. The Committee for 1904 was under the Presidency of the Lord Mayor. It contained a physician and a surgeon from the great hospitals, and six others, one of whom was Sir Sydney Waterlow, a gentleman whose aversion to the small hospitals has, we believe, never been concealed. Under such circumstances, we contend that the case of the small hospitals was not likely to be fully considered on their individual merits. In other words, the constitution of the Hospital Sunday Fund is defective because it has no representatives of the small hospitals either upon the General Council or upon the Distribution Committee. Now, as Sir Henry Burdett appears willing to tell us so much about the working of the Hospital Sunday Fund, may we ask where are the minutes of evidence upon which the Council acted in the case of the Royal Orthopædic Hospital? Were the objections of the minority of governors against the sale of their site adequately laid before the Committee of Distribution? If not, why not? As we asked last week, "Did they know and not care, or did they not know and not care?" Or did Sir Sydney Waterlow, whose acquaintance with City men and City ways is not less exhaustive and particular than that of Sir Henry Burdett, agree with that gentleman that the names of such financiers as Mr. Harry Marks, Mr. Head, and Major Ricarde-Seaver were sufficient to guarantee wise dealing with the valuable site that once belonged to the Royal Orthopædic Hospital? The contention of the Hospital Sunday Fund that they did not advise sale falls to the ground in the face of the personal evidence to the contrary by one of the hospital surgeons, a man of unimpeachable honour. Besides, they advised amalgamation, which, backed with the leverage of grants, comes to much the same thing. In any case, there is no attempt to deny that the King Edward Fund pressed amalgamation on the Royal Orthopædic Hospital. The public are entitled to ask if that policy was adopted with a full knowledge of the facts of the case. If so, where are the minutes, and what is the explanation given by the King's Fund for advising sale at a price £12,000 below that eventually obtained? The £12,000 of which Sir Henry Burdett speaks so lightly was saved to the charity by the opposition of the determined minority, who faced the majority that sprang up round Mr. Marks after his first appearance on the scene in 1898. The affair resolves itself into the question whether the Funds are going to enforce any particular policy on a given hospital regardless of economic consequences? Where do the Funds intend to

draw the line? Are they to enforce certain views held by some of their leading philanthropic members, or are they to act on well-considered and clearly defined principles in their attempt to control the management of the medical charities? Piecemeal work in this latter direction will be worse than none at all. The King's Fund pressed the sale of their former site on the Royal Ophthalmic (Moorfields) Hospital, a step that was followed by financial ruin. Why did they not press amalgamation on the Royal Ophthalmic Hospital as they have done on the Royal Orthopædic and the City Orthopædic. With the fate of their predecessors before them, the City Orthopædic will do well to shut their ears to the blandishments of the Funds. The Sunday Fund made in 1904 an award of £1,600, and in 1903 the King's Fund one of £2,000 annual grant and £2,500 donation to the Royal Ophthalmic Hospital to eke out bankruptcy due to the sale of an enormously valuable City site. Did the Funds originally investigate the facts before advising or approving that particular sale? If not, again, why not? It is surely not asking too much that the Funds should state to what extent they assert their right to control the actions of individual charities and that they should make public the grounds upon which awards are made or withheld. Further, we think the constitution of the Funds, and especially of their Distribution Committees, should be widened, so as to include representation of all medical charities, great and small. There should also be a right of public appeal in the case of a non-award. As there seems to be some misapprehension of our motives in certain quarters, we may conclude by saying once again, emphatically, that we are second to none in our admiration of the honour and the high aims of the Hospital Sunday and the King Edward Funds. Indeed, were it not for our profound trust in the unerring tact and justice of the Royal Family, who are so intimately concerned with these great modern philanthropic enterprises, it is probable these articles would never have been written. As it is, although we may not succeed in obtaining any adequate published answers to our contentions and suggestions, we nevertheless feel confident that the era of more perfect and, from our point of view, of fairer administrative justice will be speedily established in the Funds.

YOUTH AND INTELLECTUAL ENERGY.

ROBERT LOUIS STEVENSON, who would himself have remained young had he lived to a hundred, always maintained that the young deserve our respect equally with the aged. Each period has its own message to the world, and each deserves its measure of respect, but the disproportionate respect we are accustomed to pay to age is, he used to suggest, like that paid to sex, the expression of pity by the strong for the weak. However that may be, we think there is a tendency to overlook the important part played by young men in the intellectual life of their time. Pitt was Chancellor

of the Exchequer of England at twenty-one, and Byron wrote "Childe Harold" at twenty-three. In the realm of poetry, indeed, the preponderance of the work of youth is more generally admitted than elsewhere. Few poets have achieved fame who did not win their first laurels under five-and-twenty, and many of the greatest—Chatterton, Byron, Shelley, Keats, to mention no more—died in comparative youth. The field of science, and more particularly of medicine, is commonly regarded, however, as the special preserve of the experienced, and it is with some surprise that, on reflection, one is led to the conclusion that most great advances have been made by young men. We may take, almost at random, some of the greatest names in medicine, and test the truth of this remark. Virchow, for instance, began his series of investigations in pathology before he was twenty-five, and his theory of cellular pathology took definite shape not many years later. Morgagni, in Virchow's phrase "the father of modern pathology," sowed the seeds of that science when, as a medical student, a mere boy, he began keeping notes in parallel columns of the clinical history of the patient, and of his observations in the *post-mortem* room. Laennec began his methods of diagnosis when he was but little over twenty, although he allowed them to ripen for twelve years before he published them at thirty-five. Auenbrugger, his predecessor in examination of the chest, was little older when his great idea of percussion occurred to him. When Bright was thirty-five he taught the world nearly all it has ever known of inflammations of the kidney. The great men of the Dublin School of half a century ago did their most notable work before they were thirty. Corrigan, from the age of twenty-five to that of twenty-nine, studied the disease that ever since, by the suggestion of Trousseau, bears his name, in a hospital where there were only six medical beds. Stokes, at twenty-one, introduced the stethoscope from France to this country, and a few years later wrote his classic description of Cheyne-Stokes' respiration. To come to more modern times, Lister had not reached middle life when his epoch-making discoveries were made. Major Ronald Ross is, we are glad to say, still a young man, and it is several years since his researches on malaria placed our knowledge of that disease on a new plane. Finsen was still young when the hand of death stilled the energy of his intellect. We have instanced more than enough names to support the claim that youth and boldness hold their own against age and experience in the onward march of knowledge. Young men, therefore, should exercise their prerogative to the full, and should not, in attempting to lay foundations unnecessarily wide, dissipate that energy which properly directed should raise the walls of the house of knowledge.

A NEW BRITISH CONSTITUTION WITHOUT MEDICINE.

THE introduction of medicine as a factor into State business is an event of recent date, but so

quickly has it justified that introduction that one is frequently apt to fancy that the science of public health has taken as firm a grip of the British politician and Government official as its importance warrants. When public men come to medical dinners they always assure their hosts that the good medicine has done to the community by its preventive work is inestimable, and that they themselves will do all in their power to help forward the cause of public health. Happily, many of them are doing their best; but it is important for the profession to realise how little weight medical counsels in this country still have in State matters, and how many admirable publicists still regard hygiene as merely a hobby of the doctors. In Germany, France, and even America the requirements of the public health are thought worthy of more consideration than are afforded by their administration in a subordinate department in a minor Government department, but England remains content with its Local Government Board, and is satisfied that the head of its medical organisation shall receive a salary one-tenth that which the chief lawyer and the chief priest of the realm are paid, without enjoying any official status beyond that which he holds in virtue of his seniority in his department. This we are accustomed, if not reconciled, to, and when we look for change we are apt sometimes to turn to the reforming Radical to set matters on a more equable footing. Those who cherish this fond hope will, we fear, be somewhat disappointed if they read *Truth*. In his last number for 1904, Mr. Labouchere outlines a scheme for amendment of the British constitution on lines which he thinks every member of the rank and file of the Liberal party would agree with. Needless to say we have no concern, as an organ of general medical opinion, with the detail of the reforms there set out, beyond remarking that they are projected on the widest democratic principles. But what interests us chiefly is the constitution of the Senate, a body which is to take the place of the present House of Lords. This Senate is to embrace the collective, matured wisdom of the country in the persons of representatives of all the leading interests and professions. The Senate is to review the decisions of the House of Commons and to send back such legislation as it judges hasty or imperfect, besides exercising the usual functions of a deliberative body—the discussion of public questions and the passing of resolutions. The electors to the Senate are to be the members of the House of Commons, and they are to choose for the seats in the Upper Chamber three ex-judges, three financial experts, three manufacturers, three wholesale merchants, three retail traders, three admirals, three generals, three literary men, three architects or painters, twelve artisans—and no doctors! Without casting any aspersion on the other professions, we should have thought that the voice of such a man as Lord Lister—the only medical representative in the present House of Lords—might have been as

useful to the State as that of a painter or an artisan, when questions of public health—and there are few matters of State interest in which questions of public health are not involved—were under discussion. We venture to hope that the omission of medical men under Mr. Labouchere's scheme is an oversight, as the editor of *Truth* has a genuine respect for the proprieties of medical practice, even if he sometimes finds himself at variance with current medical views, and he is the implacable foe of the quack and impostor in every shape and form. But granting that it was intended to give a certain medical representation in the reformed Upper Chamber, it cannot be denied that there is a significance which should be missed in the failure to include them. This failure shows that the paramount claims of public health in regulating and modifying every scheme of solid amelioration or improvement are not yet recognised even by the most ardent reformers, and that there is a *soupcçon* of truth in the gibe which each political party hurls at the other that social welfare is regarded as secondary to other considerations. For ourselves, we make no complaint, beyond saying that it behoves medical men, in whatever station they are placed, to continue to work in season and out of season to keep questions of the physical well-being of the nation constantly to the front, for—apart from religious and moral considerations—there is no matter that affects happiness and prosperity to the same extent, and none that is more easily overlooked.

Notes on Current Topics.

A Loyal Gift to a Royal Fund.

THE humane modern spirit, in its finer phases, has perhaps its most noble expression in the great medical charities and in the great collecting agencies known as the "Hospital Funds." So far as London, the greatest city in the world, is concerned, Royalty has all along been closely identified with that movement. As everyone knows, the King's Hospital Fund for London was founded by King Edward, when Prince of Wales, to commemorate the Diamond Jubilee of Her late Majesty Queen Victoria. The King's wish has been to bring the fixed income of the Fund to £50,000 a year, but hitherto the total has been £14,000 short of that amount. Every inhabitant of the United Kingdom will rejoice that the greater part of the required sum has been most generously provided by Lord Mount Stephen, who has handed to the King bonds that yield an annual sum of £11,000. This munificent gift leaves £3,000 a year still to be provided, a gap that will doubtless be bridged over by some other friend of mankind. The King may be congratulated not only on having initiated so noble a scheme, but also in having loyal subjects willing and able to place its superstructure upon a sound and permanent foundation.

Stimulants in Literary Work.

THE medical profession is probably the most prolific of all callings in the production of books

and papers, and considering the amount of interesting material daily presented to its members, it is not wonderful that they should fly so frequently to print. There are few doctors who have not in their time written one or more professional papers, and a good many have contributed a considerable number to the columns of the professional weeklies and monthlies. All, except a chosen fraction, must, therefore, have experienced the difficulties of choosing the right word, selecting the exact construction, and conjuring up the most suitable metaphor with which to clothe and illustrate their meaning. They will, then, be interested in an article, in the *Cornhill*, entitled "Throes of Composition," in which the experiences of many eminent writers are related, and especially in that portion of it that refers to the aids to thought and expression adopted by well-known men. Thus Sheridan used port to bring out the ideas that lay a little too deeply imbedded in his brain; Wilkie Collins produced "The Woman in White" largely with the help of champagne; Fielding trusted to brandy and water; Charles Lamb sought the aid of wine or beer; whilst the great lexicographer depended on tea to carry him through his herculean task. But such artificial aids, excepting, perhaps, Dr. Johnson's, are not likely to find approval in this temperate age, and we think that most medical men will sympathise more with Milton, Kingsley, Buckle, and Tennyson in their partiality for tobacco. Cavillers at the weed may find their objections difficult to maintain in the face of the examples of the authors of "Paradise Lost" and "Maud," and we know of many treatises on more prosaic but none the less necessary subjects that would not have been produced except under the ægis of the same drug. Nor do we forget that Mr. Spurgeon used to defend himself by saying that he could smoke cigars to the glory of God.

A Graceful Concession—to Influenza.

THE key to the prevention of disease lies in the study of causes, and foremost among the methods by which causes should be reviewed is the statistical one. It is also the most technical one, and for this reason the one that is most likely to be eschewed by the female mind in search of information. Swedish ladies, however, may be more mathematically-minded than their sisters, for the ladies of Haparanda have been making researches in etiological statistics that have brought to light hitherto unsuspected facts. The chief of these is that during cold weather men suffer three times more often than women from influenza, neuralgia, colds, and similar maladies. The gentleness of these Haparanda ladies has been much touched by this discovery, and extending their inquiries, they have come to the conclusion that the root of this unhappy state of things lies in the demand that politeness makes on the sterner sex to expose their heads to sudden changes of temperature each time they meet a female acquaintance. They have therefore graciously let it be

known that they will not expect their men friends to take off their hats in the streets during the cold weather, but that they will consider the usages of good breeding satisfied if the military salute be given. This is very nice and considerate of the ladies; we only hope the gentlemen will not forget to revert to the more established form of salute when the weather grows warmer. But the fears of Haparanda need not flutter the feminine dove-cotes west of the North Sea. The race of men, however, must indeed be degenerate that needs fear a bare head in any British weather. We prefer to believe that the national robustness is better testified to by the movement in favour of no hats at all, which has lately found adherents and converts among both men and women.

Sight-testing Again.

WE have commented already on the attempts that are being made by various bodies of unqualified persons to procure for themselves certain privileges as regards sight-testing. Chemists, optical instrument dealers, and others, wishing to adopt sight-testing as a "side-line," obtain certificates of proficiency from some body or other, such as the British Optical Association or the Spectacle-makers' Company, and thereupon pose to the public as experts. An interesting development of this movement is the proposal of the British Optical Association to promote a Bill in Parliament "to define and regulate the practice of optology." The projected Bill would enact that a register of "optologists" should be established, on which every person practising "optology," medical men excepted, must have his name enrolled. Admission to such register would be gained either by proof that one has been engaged for a certain length of time in the practice of sight-testing, or by possession of some such certificate as we have mentioned above. It is hardly necessary to point out to medical men that such claims to registration are valueless as marks of knowledge, and that, as far as the medical profession is concerned, we can countenance no attempt to endow any body of tradesmen or mechanics with the privilege of pursuing a branch of medical practice. The operation of testing the sight is part of the general examination of the eye, and requires for its performance a knowledge of physiology and anatomy, of the possession of which there is no guarantee outside the medical profession. The proposal of the British Optical Association need hardly, however, be taken seriously, for Parliament cannot for a moment consider such an audacious demand.

Flies and Tuberculosis.

A VALUABLE and original contribution to the etiology of tuberculosis is contained in the *Boston Medical and Surgical Journal* for December 15th, 1904. Lord, writing in that journal, details the results of some experiments he has been making with regard to the rôle played by flies in the dissemination of tubercle bacilli, and his work,

having been very carefully performed, throws a significant light on the doings of this oft-suspected insect. Lord had often noticed that flies showed a special predilection for feeding on sputum, even when other food was available, and he therefore set about and deliberately allowed them to partake of tuberculous expectoration, with a view to examining their droppings afterwards. He found that not only did the tubercle bacilli pass through the alimentary canal in a comparatively short time, but that when recovered from the excreta some of them were able to live for fifteen days afterwards, thus showing that they had lost none of their vitality. Indeed, they would seem to have increased, for the excreta of flies fed on sputum exhibiting ten tubercle bacilli per microscopical field were found to contain no less than a hundred and fifty per microscopical field. Paraffin sections were made of the flies, and tubercle bacilli were demonstrated in the actual intestinal contents, though the organs themselves seemed free. A noticeable feature about the bacilli recovered from the droppings was that these were larger than those in the sputum, and in some instances showed a tendency towards branching. Lord dwells upon the obvious moral to which his experiments point, and with his experience before one's eyes that moral cannot be too closely taken to heart. If we cannot have "anti-fly" campaigns in this country, we can at least take every precaution to guard our food from contamination by flies, but even these leave loop-holes for infection that it is not very comfortable to contemplate.

Fatigue Antitoxin.

INTEREST in the subject of fatigue will probably continue as long as people know what it means to feel tired, and a good deal of interest has been aroused in lay minds by Sir William Gowers' erudite article on "Fatigue" in the *Quarterly* for October. The latest views on the subject are there set out, and it is particularly noticeable that physical and mental exhaustion are shown to be intimately related one with another. Fatigue is due primarily to the manufacture in the tissues, and especially in the muscles, of toxic waste products, and it occurred to Weichardt (a) that if this were so, it ought to be possible to obtain an antitoxin capable of neutralising this toxin, and of enabling the exhausted tissues to renew their youth like the eagle. He therefore set to work attempting to extract from the muscles of fatigued animals the toxin that had been manufactured in them, and this he was able eventually to obtain by dialysis of the extractives. Very small quantities of the body thus obtained will, when injected into animals such as rats, mice, and guinea-pigs, give rise to all the symptoms of fatigue, and larger quantities will produce death. These results were verified by control experiments made on similar animals with injections from the dialysable muscle extracts of unfatigued animals, the injected

(a) *Monch. med. Woch.*, November 29th, 1904.

animals in these cases showing no particular disturbance. The introduction of this dialysable toxin into a horse's circulation gave rise to the formation of an anti-body, which was able to neutralise the toxin both within the tissues and *in vitro*. The antitoxin so obtained was found to be a stable body of great potency, capable of neutralising ten times its weight of toxin. Weichardt now administers the antitoxin to man by the mouth, and claims that the subject is able to accomplish more work without fatigue than before, and that if taken continuously it greatly increases the power of work and the enjoyment of it. Most schoolmasters, we fancy, would be glad to have an occasional dose of this antitoxin by them; indeed, there are few walks of life in which it ought not to prove useful. The gentlemen who are "born tired" will now be without excuse.

Paget's Disease of the Nipple.

THE pathology of Paget's disease of the nipple has been the subject of much discussion since the description of the condition by Sir James Paget in 1874. The important clinical points are the intractable nature of the complaint and its liability to be followed by malignant disease. Mr. Mayo Robson, in his recent Bradshaw Lecture, referring to pre-cancerous conditions of the breast, advised excision of the nipple if eczema of that structure did not speedily yield to treatment, and he has met with some criticism for so doing. That eczema of the nipple is followed by cancer in some instances is undoubted, but opinion would seem to be still a good deal divided as to the frequency of the sequence. It is interesting in this context to notice that Jacobäus, in a recent paper (a), concludes, as the result of his observations, that Paget's disease is cancerous in nature from its outset, and always starts in the glandular epithelium of the galactophorous ducts. The slow progress of the malady he attributes to the resistance to extension offered by the muscular and fibrous tissues, so that if the growth is deeply seated it more readily progresses along the ducts than into the breast substance. The so-called Paget's cells he regards as detached cancer cells. Jacobäus' view is hard to reconcile with the fact that nipple-eczema sometimes is cured without giving rise to further trouble, but it lends weight to the advice that the conditions should be seriously regarded, and submitted to surgical treatment without undue delay.

Japanese Losses in the War.

A RECENT number of a Japanese contemporary (b) gives interesting tables regarding the losses undergone by the Japanese navy during the present war. From February 9th, when the first losses took place at Port Arthur, up to October 9th, the total number of killed and wounded of the Imperial Navy was 2,321, of which 1,022, or nearly one-half were killed. The greatest loss on any one day was that at Port Arthur on May 11th, when

a total loss of 921 took place, 494 being killed. Among these were Fleet-Surgeon Seki and Surgeons Uyemiya and Kusaka, who went down with the ships *Hatsuse* and *Yoshino*. Again, in the engagement in the Yellow Sea on August 10th, 65 men were killed and 161 wounded. In addition to the medical officers we have mentioned only three other surgeons have been lost during the war. Six were wounded, but are now quite recovered and again at service. The hygiene on the Japanese ships must be excellent, for only six surgeons and thirteen medical attendants were attacked by infectious disease—dysentery or typhoid fever. We are glad to state in the quaint phrase of our contemporary "none of them did die of the diseases."

The International Congress of Medicine.

WE have received the fourth number of the "Official Journal of the International Congress of Medicine," which is to meet at Lisbon on April 19th, 1906. From the subjects chosen, the number of papers already promised, and the names attached to them, it is evident that the meeting will be one of great interest. We understand that all the papers will be printed in advance, so that the confusion of tongues, of which complaint has been made in the past, will be to some extent obviated. Among the English medical men who have promised to take part are Mr. D'Arcy Power, who is to discuss "The Causes, Sequelæ, and Surgical Treatment of Ulcers of the Duodenum"; Mr. Treacher Collins; Dr. Samuel Osborn, of Datchet, who is to make a communication on "An Armoured Motor Ambulance as a First-Aid Dressing Station"; Dr. Stanley Atkinson; and Dr. F. W. Mott, who is to read a paper on the "Histology of Sleeping Sickness." The Journal contains a list of the various national committees which have been formed to prepare the work of the Congress. The British Committee is a representative one, Dr. Pavy being President. We notice that the University of London is to send to the Congress a special delegation consisting of Sir Thomas Barlow and Professor Waller.

Unqualified Chemists.

OUR readers are aware that by a misuse of the Companies Act unqualified persons have been able to evade the legal responsibilities of the dental profession, and by enrolling themselves as limited liability companies have been permitted to practise dentistry without let or hindrance. Similarly, through a flaw in the Pharmacy Act of 1868, adroit persons, without the necessity of possessing any knowledge of chemistry or pharmacy, have, by forming companies, made themselves free to carry on business as chemists. Such traders are bound by none of the restrictions imposed by law on registered chemists and druggists, and are free from certain conditions, such as those with regard to the storage of poisons, which are considered necessary in the public interest. Some of these businesses have been attracting much attention to

(a) Virchow's *Archives*, Vol. clxxviii. No. 1

(b) *The Sei-i-Kwai Med. Journ.*, October 31st, 1901.

themselves recently by their extravagant advertisements, in which they impudently contrast their methods with those of the "ordinary retail chemists," as the legitimate trade is termed. It is stated by one of these firms that their drugs are purer, of higher quality, and cheaper than those sold by other chemists, and that this superiority is possible because of the large trade done by them. Every trader speaks well of his own goods and there is no need to take these claims more seriously than other trade announcements. At the same time, medical men are well aware that "cheapness" in itself is not necessarily a point of merit in drugs. From the point of view of the public, moreover, it is of much more importance that the sale of drugs and the dispensing of prescriptions should be in the hands of skilled, careful, and responsible persons, than that drugs should be cheap or even of high quality, important as this may be. Medical men will do well then to see that their prescriptions are made up by qualified chemists, and to warn their patients against being misled by specious promises to trust incompetent persons.

The Fatal Accident at the London Coliseum.

THE death last week of a jockey, riding in the realistic horse-race at the newly-erected Coliseum in London, forces the subject of dangerous performances once again before the public conscience. For the benefit of provincial readers it may be explained that real jockeys on real racers ride an imitation Derby on a rapidly revolving platform. It is needless to point out that the planting of a horse's foot on the non-revolving centre of the platform would lead to instantaneous somersaults. The fatal accident a few days ago resulted from some such mishap. The whole performance is so absolutely dangerous to life and limb that in our opinion it should be stopped at once. The London County Council should assert their right of control and put an end to these disgraceful exhibitions. In the case of the Coliseum they can interfere, if only on the ground of danger to the audience. Should one of the racers fall on the revolving platform, the deadly havoc that might instantly be wrought is terrible to contemplate. The fall of a leading horse would rake the field as if a volley of shrapnel were fired into the ranks of the racers. The management of the Coliseum, having now had due warning, will have to be held responsible for any subsequent accident in this part of their performance. Prevention, however, is better than cure in horse-racing as well as in other mundane matters.

The Proposed Sterilisation of the Unfit.

IN another column will be found a communication from Dr. R. R. Rentoul, as to his scheme for the prevention of degenerate offspring. Whatever the future may have in store, it seems tolerably clear that the philosophy of modern civilisation is not yet ripe enough to carry any such proposal into practice. The summary methods of the Spartans

long ago weeded out degenerate children as fast as they were produced. Dr. Rentoul would go deeper and prevent the begetting of children by certain groups of degenerate parents, such as idiots, lunatics, and criminals. His radical method is to sterilise parents of both sexes who may be found by the State unworthy to have offspring. One great difficulty is to determine the parental degenerate, and the next to appoint the State executioner. Some day mankind will doubtless attain some sort of intellectual and moral millennium in which the sterilisation of degenerate parents will become an established practice. Meanwhile it is evident that the yearly production of an enormous number of physical and mental degenerates inflicts a gross injustice upon the unfit offspring, and an intolerable burden upon the community. The release of so-called "cured" patients from lunatic asylums for recurring periods, during which they go home and beget more children, is a scandal and a reproach to an otherwise enlightened and progressive system. Even "cure" may be purchased at too dear a price.

The Hon. Sydney Holland and the London Hospital.

WE have published several letters from Mr. Sydney Holland with regard to the money advanced by the London Hospital to its attached medical school for the purpose of purchasing a sports ground for the students. Mr. Holland's explanation certainly places the affair in an aspect different from that presented recently at the Sunday Fund meeting. We are pleased to accept his proposition that the money advanced by the hospital is covered by ample security and by a fair interest paid by the school as rent. It is reassuring to learn, moreover, that the accounts of the medical school are open to the public. It has often been stated in these columns that we have implicit trust in the good faith and honour of Mr. Sydney Holland. As a public man, however, he must expect criticism. We have unbounded admiration, moreover, for that splendid charity, the London Hospital, over which he presides. At the same time, these feelings will not prevent our offering criticism when it seems to be needed. We still think it a pity that a better defence could not be found in answer to a public question as to the alleged diversion of charitable funds than to cast aspersions upon the questioner. Mr. Holland's case is a strong one, in our opinion, and capable of reasoned defence of a sufficiently powerful description. Meanwhile hospitals and hospital chairmen must learn to formulate their administrative policy in such a way that everything may be clear as daylight to the man in the street.

PERSONAL.

It has been announced that Surgeon-General W. J. Fawcett, C.B., will shortly be ordered to go from Dublin to London to take up the duties of Deputy-Director-General of the Medical Service under the new Army scheme, and will be relieved in Ireland by Surgeon-General Donovan, C.B.

THE KING AND QUEEN last week visited the Devonshire Hospital at Buxton. His Majesty promised Dr. Turner, the Senior Medical Officer, a new glass operating table for the use of the hospital.

HER MAJESTY THE QUEEN has sent ten brace of pheasants to the Royal Waterloo Hospital for Children and Women, of which Her Majesty is one of the oldest patronesses.

At the meeting held on December 27th, 1904, of the Paris Academy of Medicine, after keen competition M. Chamberland was elected as "*associé libre*" of the Academy of Medicine on the third ballot by 53 votes in room of the late lamented M. Duclaux.

DR. W. ST. C. SYMMERS, of Cairo, has been appointed Musgrave Professor of Pathology at Queen's College, Belfast.

LORD MOUNT STEPHEN has presented bonds to the value of £200,000, yielding an annual income of £11,000, to King Edward's Metropolitan Hospital Fund.

SIR JOSEPH FAYRER, M.D., F.R.C.P., Bart., K.C.S.I., now residing in Falmouth, has recently celebrated his 80th birthday.

THE new headquarters of the Manchester Companies of the Army Medical Corps were opened on the 7th inst. by Major-General M'Kinnon, Director-General of Auxiliary Forces.

MESSRS. ALLEN AND SON, solicitors, Carlisle Street, Soho Square, W., have made the first three endowments of the Jessie Alice Palmer Charitable Fund, under the bequest of £1,000 each in memory of Jessie Alice Palmer. They are as follows:—£1,000 to Westminster Hospital, in recognition of the services to science of Dr. William Murrell, F.R.C.P.; £1,000 to Queen Charlotte's Hospital, in recognition of the services to science of Dr. W. S. A. Griffith, F.R.C.P.; and £1,000 to the British Home for Incurables.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

EDINBURGH.

EDINBURGH ROYAL INFIRMARY.—The annual report of this institution, presented to the Court of Contributors at the statutory meeting of January 2nd, contains, in addition to the usual financial and statistical statement, paragraphs dealing with the re-organisation of the surgical out-patient department (which has been the subject of considerable criticism in the Press within the past year, on account of alleged delay in dealing with casualties) and with the age limit question. In the new scheme for the treatment of surgical out-patients, the feature to which the managers attach most importance is the arrangement whereby there shall be a continuous supervision of the department by a responsible officer. This is to be obtained by putting it under the sole charge of one of the assistant surgeons, in rotation, for four months at a time, during which period he will be freed from all other duties and be present in the department daily at 11 a.m. To assist him a special staff is to be provided, consisting of three resident surgeons, dressers, nurses, a registrar clerk, and two day and two night porters. One house surgeon will be present in the department during each hour of the day or night; and two during the ordinary out-patient hours. To allow of the proper working of the scheme the present out-patient rooms will require to be reconstructed and a small operating theatre built. After recapitulating the various phases through which the age limit question has passed since last report (these have from time to time been announced in this column and need not be

repeated), the report goes on to say that, although in the decision of the Court of Contributors, which the managers loyally accept, no mention was made of any exceptions to the rule that members of the staff shall retire at the age of sixty-four, the managers assume that it was the intention of the Contributors that the rule should not apply to members of the full staff serving their second or third terms of five years. The report was, as usual, remitted to a Committee of Contributors for report to an adjourned meeting, and the proceedings on January 2nd were largely formal. The Lord Provost's observations on the new rules were met with applause, and it is to be hoped that the view expressed will ultimately be agreed upon. He said he took it for granted that the age limit would not apply to the present professors; he understood that the promoters of the new rule took the same view. It would be most unfair to apply the rule to gentlemen who had been appointed under certain conditions, and if this were agreed to, harmonious working would be secured and friction avoided. Nor should the rule apply to members of the ordinary staff, who were serving their second or third term. It is generally felt that if the Contributors now endorse the managers' action, they will alike safeguard vested interests and promote a most desirable reform.

MEDICAL AND DENTAL DEFENCE UNION OF SCOTLAND.—From the details given in the second annual report of this Union, which has just been issued, it is quite evident that a useful organisation has been placed at the disposal of members of the profession. During the year the membership has increased to 615, 149 more than the 1902-3. From the examples given in the Report of the work done by the Union, it is gratifying to learn that in comparatively few cases was recourse to litigation found necessary, and that the Union is evidently being largely taken advantage of by members requiring advice in delicate matters, ethical and otherwise, affecting their professional interests. On account of the differences between Scotch law and that of England such a society as this was really a necessity, and the gratifying increase in its membership during the year is a proof of its usefulness.

GLASGOW.

PRELIMINARY EXAMINATIONS AT SCOTTISH UNIVERSITIES.—The results of the preliminary examinations at the four Scottish Universities—St. Andrew's, Glasgow, Edinburgh, and Aberdeen, for the year 1904, have just been issued, and show a stringency of examination which indicates that the standard has been raised considerably. The influx of students to the Universities, of those anxious to avail themselves of the Carnegie Fund, is in all probability responsible for the large number of failures at the various examinations. In future we understand the Carnegie students will have to pass the examination in Arts. The numbers entering for several subjects seem to be very considerably larger at Glasgow than at Edinburgh University, the actual numbers being: Glasgow 1,327, Edinburgh 752; failed at Glasgow 558, passed 449; failed at Edinburgh 329, passed 272. These figures do not represent the number of students, of course, but the number of entrances for the different subjects, some students entering for two, three, or four subjects. It was thought that at the last medical preliminary examination in Glasgow University in September the marking in some of the subjects was unduly severe, and therefore the number of failures unusually large.

GLASGOW SOUTHERN DIVISION OF THE BRITISH MEDICAL ASSOCIATION.—On Thursday evening, the 5th inst., a general meeting of the members of the above Division was held in the Library of the Medical Club, 22 Carlton Place; the Vice-Chairman, Dr. Alex. Miller, occupied the chair in the unavoidable absence of the Chairman, Dr. James Hamilton. Dr. C. E. Robertson, the representative of the Division at Oxford, gave an interesting account of his stewardship there, and of the work done by the collective

body of Representatives at their meetings held at Oxford last year. The subject of Contract Medical Practice was then discussed, and considerable progress was made, but it was agreed to delay the further discussion of this important subject for a fortnight. The Division has arranged to hold fortnightly meetings on account of the large amount of work to be overtaken during the next few months. This is one of the most active of the various Divisions. The profession in the City has been divided into four divisions—Northern, Southern, Eastern, and Central. Hitherto the difficulty has been to get the members to attend the meetings. The attendances have been small at the various divisional meetings in the past, and in view of that it has been suggested that, instead of having so many separate meetings, the experiment might be tried of holding conjoint meetings occasionally. This branch of the Association work has not got beyond the experimental stage; and now the members have the opportunity given them of having existing grievances redressed, it is quite remarkable the amount of apathy that prevails with reference to the work sent in from the Council of the Association in London for the consideration of the different Divisions. The meagre attendance at meetings is not confined to Glasgow nor to Scotland, as we read in the supplement to the *British Medical Journal*, of Saturday, January 7th, 1905, that at a meeting of the Birmingham Branch, Central Division, when the important and clamant subject of Contract Medical Practice was under consideration, that there were 14 members present, and 278 absent! If this lack of interest on the part of members of Divisions in business which closely concerns them individually and collectively should unfortunately continue it will have to be seriously considered whether the original state of matters should not be reverted to. It ought to be remembered by members of Divisions that the expenses incurred in carrying on the work are considerable. The Association yearly allowance of 4s. per member is a fairly generous one, and it is to be hoped that the members of Divisions will begin to take a greater interest in the abundant work which lies to hand, and so justify the large expenditure involved, and the existence of the Divisions as at present constituted.

INTERESTING MEDICO-LEGAL CASE.—IS INSANITY A DISEASE?—A case of considerable interest to the medical profession has just been decided by Sheriff Principal Sir John Cheyne, in an appeal against a judgment of Sheriff Substitute Lyall of Paisley. A member of the Irish National Foresters became incapacitated for work from bodily sickness, which in course of time culminated in insanity, and this required his removal to an asylum, where he was confined for two or three years. His friends raised an action against the Friendly Society for aliment, and this action the Society defended on the plea that the man was not suffering from bodily disease, but from insanity, and that the rules of the Society only allowed of aliment being given in cases of bodily sickness. After the examination of many witnesses, including a number of medical men, the Sheriff Principal sustained the judgment of the Sheriff Substitute in favour of the defenders, the Friendly Society, and went on to say that he concurred with the Sheriff Substitute in holding it to be a fair result of the medical evidence that pursuer's inability to work was not due to bodily sickness in the ordinary and natural sense of that term, but was due to insanity. He had come to this decision with a good deal of difficulty, as the rule of the Society applying to bodily sickness was rather awkwardly expressed. He had to concur with the Sheriff Substitute in holding the Friendly Society in the right on the merits of the case. He hoped, however, the Society would see its way to render the family more assistance from their Benevolent Fund. We refrain from commenting on this interesting case as we understand that it has been appealed to the Court of Session, where it will probably be discussed at no distant date.

BELFAST.

THE CHAIR OF PATHOLOGY IN QUEEN'S COLLEGE—As announced in these columns last week, Dr Simmers, of Cairo, has been appointed to this chair, in succession to Professor Lorrain Smith. Some disappointment has naturally been felt, especially by the younger medical men, at the non-success of the local candidate, but it is generally recognised that Dr. Simmers' claims were very strong, his experience being so wide. His record in Cairo has established his reputation as one of the foremost of the younger pathologists, and he will find in Belfast a flourishing school with ample opportunities for work, and abundant post-graduate assistance.

THE BELFAST CORPORATION AND PUBLIC HEALTH.—At its monthly meeting held last week, the Corporation devoted several hours to discussing the rather serious state of the health of the city, and attention is being drawn in the daily Press to some of our more glaring faults. As the *Northern Whig* very sensibly remarked, "Modern sanitary science has rendered it an impious act for man to lay upon Providence the blame for his own sins of omission and commission in the matter of health." During last month no fewer than 222 cases of zymotic disease were reported, including 58 of scarlet fever, 32 of typhoid, 21 of smallpox, and 17 of diphtheria. There were 79 deaths from zymotic disease, 89 from phthisis, and a death rate of 22 per thousand. Perhaps the most pressing matter is the smallpox outbreak, which is again assuming unpleasantly large proportions. There were 29 cases during the month, and 37 cases are now under treatment at Purdysburn, all the beds in the hospital being full. At the intercepting hospital 50 contact cases are under observation. Meantime the Belfast Board of Guardians can find no better occupation than discussing the action of a dispensary doctor who, following the instructions he received from the public health authorities, vaccinated the children in a school in an infected district without waiting to consult with their parents. The sapient Guardians, after a prolonged discussion, passed a resolution condemning his action, which resolution, however, is not likely to affect that gentleman's happiness. Smallpox is not by any means the only source of danger to the public health at the present time. There are no effective guarantees of the purity of the milk sold in the city, and overcrowding is rife in certain quarters. Altogether there is a fine opportunity for an energetic reformer, but as yet none has appeared.

Correspondence.

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

PROPOSED STERILISATION OF CERTAIN DEGENERATES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your issue of the 28th, a communication, well worth reading, appears from Dr. W. McDermott. But Dr. McDermott says what I think he does not mean, when he states that he would not care to decide who shall and who shall not be sterilised. Now our last census showed that there were in the United Kingdom, on one day, 60,721 idiots, imbeciles, and feeble-minded; and of this number, 18,900 were married. Does any doctor contend that these are a good or a bad stock to breed from? Does any doctor wish to agree that his daughter may marry one of these degenerates? As these poor wrecks of humanity will not refrain from procreation, the only plan is to sterilise them. Some contend that life-long incarceration will meet the difficulty. It will not. The cost of life-long incarceration of all degenerates likely to beget degenerate offspring would amount to about £80,000,000 per annum, and surely the taxpayer is already overburdened? Take again the habitual criminal and habitual inebriate. Can these people be expected to beget a healthy offspring? They cannot, and therefore the

only plan is to sterilise them. Take again the sexua pervers—sodomists. These scum of humanity suffer from a mono-mania, and nothing more. I have heard it stated that there are some 900 of these in prisons. Now if these persons had their spermatic cords divided and ligatured, they could be made to work, and would be freed of doing harm. We have no right to give those demented persons fifteen to twenty-five years. The modern humanitarian has gone mad in this question, and with the result that we are interfering with the liberty of a goodly number of persons. I give these cases to show that Dr. McDermott and others need not have any difficulty in deciding upon these coarser types of degeneration. When we come to the finer forms, great care will be required, and to meet all cases I have proposed that no one shall be sterilised without the written consent of the Lunacy Commissioners; that only a few medicals shall be licensed to operate; that any person sterilising any person for the purpose of checking degeneration without the consent of the Commissioners shall be given fifteen years' penal servitude; that a yearly report shall be laid before both Houses of Parliament, and that if a sterilised person marry a non-sterilised person without first notifying this fact to the non-sterilised, such person shall be imprisoned for fifteen years, and further, that any person using a sterilised person for immoral purposes shall be similarly punished. What further protection can be required?

It has been suggested by me that we should obtain the consent of Parliament to sanction this operation of sterilisation. It will be difficult to obtain such sanction because it is well understood that every surgical operation is legally an assault, and that therefore the consent of patients or guardian is necessary. No law exists empowering a medical to kill the child in the womb so as to save the life of the mother, and no such proposed law is likely to be adopted. I have been told that the most supreme of all personal rights is the right to do what one likes with one's own body. If therefore, a man is discharged from an asylum as recovered (?) and lives with his wife again, would it not be best for the coming race were the man sterilised? And the same with all women who have had puerperal insanity. I fully recognise that the average man—including the average medical—does not consider it a crime to stamp a child with some mental degeneracy, or physical deterioration. The infant is of no account. It cannot defend itself. It cannot command so many political votes, and therefore the average Christian practically says, "kick it again; it has got no friends." This feature of non-protection of infant life from the disease of the parents is one of the most repulsive and damning of modern Christian life and thought. We fine a person £5 for exposing others to an infectious disease which he is suffering from, while the parent who gives a child syphilis, or some inherited degeneracy, is allowed to go free—allowed to leave the Christian court "with no stain upon his (or her) character"—as the usual jargon goes.

Now I think it full time that we medicals should establish a religion of Health, and make it a crime when people beget tainted offspring. The insane cannot be blamed, as we label them "irresponsible." Therefore we should sterilise them. If we do not, what will happen? At present, the more healthy and well-to-do are refusing absolutely to have a fair number of children, while the future race is being left to the degenerates, the poor, and the invalids. What stock must we get from this kind of breeding? Only a larger and larger number of degenerates. As illustrating this I have given two cases. In one, five unmarried weak-minded females had been confined of fifteen children in one workhouse in Yorkshire. In the other, a half imbecile female had left the asylum to marry! She had been confined of no less than nine idiot children. Do medical men mean to say they are doing their duty to the public health and public safety when they allow such things to go on without loudly protesting?

Mr. G. R. Sims has lately given the life history of two families of degenerates. They are as follows:—

The first. Wife, 37; father, 35; wife's mother for 26 years in asylum. Children—(1) Tom, constantly ailing; (2) James, all right; (3) William, delicate, always ill; (4) dead, inflammation of brain; (5) dead, inflammation of brain; (6) dead, inflammation of brain; (7) Jane, imbecile; (8) Herbert, infantile paralysis; (9) Annie, very delicate; (10) Mabel, no use of legs; (11) Emily, very delicate.

Second case.—Wife, 67, invalid. Husband, died of consumption. 11 children, 8 living. (1) girl, deaf and dumb; (2) girl, dumb; (3) boy, deaf and dumb; (4) boy, cripple; (5) girl, married.

Daughter's family.—(1) wife, insane; (2) husband, almost blind; (3) boy, normal; (4) boy, no injury; (5) girl, no use of limbs; 5 children have died.

I would like to suggest that the columns of THE MEDICAL PRESS AND CIRCULAR be at the disposal of any medical who will take the trouble to work out even one case such as the above. In this way dependable material will be at hand, more especially for the use of those who feel that heredity has more to do with such cases than environment.

I am, sir, yours truly,

ROBERT R. RENTOUL.

Liverpool, January 2nd, 1905.

THE LONDON HOSPITAL SPORTS GROUND.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The matter is perhaps hardly worth more discussion. I have told you twice that the purchase of the cricket ground was not money "spent" as you put it, but invested, and well invested by the Hospital at good, well-secured interest. I cannot see how you can possibly differentiate between the purchase of this freehold and the purchase of freehold lands in London, in which a large portion of our London Hospital money is invested, or, for a matter of that, between this investment and an investment in Consols. I think it most unfair to write of this investment as money "spent," i.e., as money that is gone and bears no interest. And I should have hoped that when your mistake was pointed out to you courteously, you would have expressed some regret. I have confused no issues. You wrote nothing about the purchase of "sites for medical schools"—our whole correspondence has been on the question of the investment of £6,000 by the Hospital in freehold cricket ground at a secured rental on lease of £240 a year.

As to the new point raised, I am blamed (of course) by you because I defended the action of the Committee of the London Hospital in refusing to accept £1 from Mr. Coleridge. We refused it because we had a right to assume that it was not given with any idea of helping the hospital, but with some sinister motive. What motive actuated the proffered sovereign we could not tell. But Mr. Coleridge is consistent. He is an anti-vivisectionist, and unlike so many anti-vivisectionists, he does not kill or pursue animals for pleasure, nor does he profit by the vivisection (without anaesthetics) of male animals to fit them for food, as he is a vegetarian. One admires him for this. Now he has preached to everyone, "Don't subscribe to the London," "Don't subscribe to Guy's" and other hospitals to which a medical school is attached where vivisection is licensed. Therefore, if he practised what he preached he would not subscribe, and we were justified in thinking that the sovereign was sent for no good purpose. I believe some other hospitals also refused his £1. I am not aware that I have ever "taunted" him, as he writes to you, "for not being a subscriber"; but really my correspondence with Mr. Coleridge has been of so breezy a nature that I can believe anything of either of us. Still, I would like to see that "taunt."

I am, Sir, yours truly,

SYDNEY HOLLAND.

Kneesworth Hall, Royston, Herts.

January 5th, 1905.

HOSPITAL FUNDS AND SMALL HOSPITALS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—“Outsider’s” letter does not go far towards a solution of the problem. He displays confusion of thought with regard to the main issues, and this needs no demonstration to any intelligent reader; but as you have printed his letter, I assume you wish me to reply. He asks me whether I “know of any physician or surgeon attached to any London hospital, general or special, who does not expect to be helped on in the world through his connection with the hospital?” I have never put this query to any of my friends; but I doubt not they would answer it in the negative. At the same time, I am sure members of the staffs of general hospitals can all point to careers of distinction won by hard work from student days onwards, through minor appointments to their present positions. The positions on the staffs of our great hospitals are the reward of professional merit and of high personal character—this latter qualification often rightly determining the result of an election. That the staffs of our great hospitals shall be really men of distinction, generally and specially, is guaranteed by an admirable system of selection, albeit some flaws in it may be possibly discoverable. Our great hospitals do not even remotely exist for the purpose of enabling practitioners to achieve worldly success. Their prime aims are the relief of the suffering poor, medical education and scientific observation and research; and they seek out and gain the assistance of the most able men available in promotion of these aims. The profession and the public quite rightly look upon our great hospital physicians and surgeons as eminent in virtue of their positions; and if some worldly success follow, it is mostly far from an adequate return for the honest toil involved in its acquisition. On the other hand, the founders of most of the older special hospitals, and the managers of some of the newer ones have been influenced by the desire, first of all, to provide a means of personal advertisement. “Outsider” thinks repetition is not argument; but perhaps he will tell us what justification to a medical reader is possible for the establishment of hospitals for deformities, or skin, or for the rectum, or ears, or eyes, or throats, or stone, or teeth, or hearts. To justify them to the public is, however, quite easy. It is only necessary to insist that no hospital for such and such a disease exists, and dishonestly to ignore the fact that the disease in question is received and treated in the out and in departments of all general hospitals. Indiscriminate charity is one of the evils of the day; the benevolent are always eager to open their purse-strings in response to a plausible cry. The plausible cry or cunning false pretence of the astute special hospital promoter has thus rarely failed when long enough persisted in.

A central London hospital board, with full powers, would certainly proceed to close all unnecessary special hospitals. The patients would be gradually transferred to the general hospitals, where the accommodation would be extended when needed, and additional specialists would be elected to carry on the extra work. The specialists would all present the best available guarantees of their claims to their titles and of their claims to the respect of their profession. Members of the staffs of existing special hospitals who could show valid claim to the distinction could be given preference in the new appointments. The mass of new clinical material would be made the best use of both in education and in science. A good deal of the sham specialism of the day would be at the same time done away with, and the public might be taught gradually to perceive that a great many maladies now classed by pseudo-specialism as special diseases, are merely symptoms of constitutional states which cannot be treated properly, or even understood, as local or special diseases. With regard to waste of funds, your leader to-day (January 4th) suggests the thought that if the property and the subscribed income of only one of the several orthopedic hospitals could be divided

among the general hospitals of London, a department in every one of them for the treatment of deformities might be opened adequately equipped for all possible demands upon it, and put, by endowment, beyond the reach of want for many a long year. The funds of the remaining useless and sham special hospitals would together do much more in similar directions. The special hospital system is fundamentally wrong, wasteful, and harmful, even when honestly conducted; when used for personal ends it inflicts deadly injury upon the profession, the sick poor, and the cause of true charity, as well as upon the progress of medical science.

I am, Sir, yours truly,

HENRY SEWILL.

January 4th, 1905.

Literature.

CAUSES OF CANCER. (a)

THE perennial attractiveness of the subject of diseases of the breast to all surgical practitioners and pathologists is one which, probably, can only terminate with the healing art itself. Special interest must always attach to the disorders of the organ which naturally functions as the source of man’s earliest nutrition—and did so before the days of the bottle-feeding and patent foods, which pretty surely furnish a trustworthy factor in the “devolution” of the race of which we have been hearing so much of recent months. And the subject of cancer, in general, is now of greater relative magnitude than at any previous period, at least of modern times; for bacteriologists assure us that they have ascertained the *causa causans* of every one of the other great plagues which have in turn tortured and decimated the human race, and has still survived into the twentieth century. And as they are confident, too, that they hold in their hands all the necessary weapons for the destruction of such enemies, the completion of the processes of sapping and mining requires only time—with the continuous services, of course, of an efficient commissariat. But the case of cancer stands alone. No microscopic decision has yet been arrived at regarding the true nature of this deadly and loathsome enemy of human life—a fact which makes its deadliness all the more weird and gruesome. Dr. Doyen’s claim cannot yet, of course, be regarded as finally settled.

The prominence of the place occupied by cancer of the breast in the minds of the healers of all ages is well shown by the allusions in the writings of the early “Fathers” of medicine which have descended to us. All give it a prominent place; all seem to regard this position of the disease as the most typical—with regard to developments and results; and the physical appearance of the “cancer” of this organ appears to have inspired the name by which the disease is now universally known. We are told by Galen—as Englished by James (of “powder” celebrity)—that: “Cancerous tumours are generated in all parts of the Body, but mostly in the women whose natural purgations are ceased, which, while under due regulation, preserve a woman in health. All præternatural tumours, therefore, of this kind, are generated of a superfluity of black bile, of which we have spoken in our treatise of Natural Powers, where we showed, that this Humour was generated in the liver, in sanguification, after the manner of Lees in Wine; but was purged by the spleen; whose natural aliment it was. . . . We have often observed in the breasts of women, a tumour very much resembling the animal called a Crab (*harkinos*); for as this creature is furnish’d with claws on both sides of its body, so is this disease;

(a) “The Clinical Causes of Cancer of the Breast and its Prevention; with Analyses of a Hundred Cases.” By Cecil H. Leal, M.A., M.B. Cantab., F.R.C.S. Eng., Assistant Surgeon to the Cancer Hospital and the Gordon Hospital for Rectal Disease. London: Archibald Constable and Co., Ltd. 1904.

the veins, which are extended from the tumour, represent with it a figure much like a crab." And elsewhere the same Colossus of Medicine gives a more definite account of the pathology of the disease in very concise terms: "When black bile settles in the flesh, if it be of the acrimonious quality, it corrodes the circumjacent skin, and breaks out in an ulcer; but if it be of a milder nature, it generates a cancer, without an ulceration." Celsus observes that: "A carcinoma principally infects the upper parts, as the face, nostrils, ears, lips, and the breasts of women. It has its original from the liver or spleen." Paulus Ægineta harps on the same string; and the notes which he elicits display a generally approximate concord with those given out by his predecessors—with, of necessity, a distinctive *klangfarbe* of their own. He informs those whom it may concern that: "A cancer may be generated in most parts of the body, as in the eyes, the uterus and other places, but especially in the breasts of women, as being of a lax contexture, and very susceptible of the grossest matter. Cancers owe their origin to black bile put in a state of effervescence, and if there be anything of an acid and corrosive quality mixed with this humour, the cancer is attended with an ulceration. Cancers are blacker than other inflammations, but not so hot. The veins all around it are bloated, and distended in the manner of the claws of a crab, whence it took its name *Cancer* (a crab); or, as others will have it, because it adheres with such obstinacy to the part it seizes, that like that animal it cannot, without great difficulty, be separated from it."

So that in the infancy and adolescence of medical science, and for tens of centuries before pathology had arrived at the years of discretion, the general idea of the terrible disease was always specially associated with the female breast. Mr. Leaf has chosen a subject of the widest pathological interest, both in cosmopolitan space and in historical time. An Analysis of a Hundred Cases embodies the results of "special inquiries into the following points: (1) age; (2) state, single or married; (3) family history, especially of cancer or consumption; (4) menstruation; (5) confinements—number of, rapidity with which they follow each other; labour, lactation (presence or absence of), duration of, manner in which it has been performed, use of applications; (6) previous diseases of the breasts; (7) injury; (8) corsets, comfortable or otherwise; (9) worry and anxiety; (10) residency—situation of, near a river, whether dry or damp, climate, drainage; (11) diet—consumption of meat, Australian meat, fish, salt, uncooked vegetables, &c.; (12) alcohol; (13) miscellaneous—general health, occupation, possibility of infection, cancer houses, etc." A glance at this list must convince the reader that hardly any conceivable aspect of the source of the disease, or available standpoint from which it can be critically scrutinised, has been omitted by the writer. Accordingly, the volume offers large claims upon the attention of all surgeons. After the perusal of the preface, the reader must expect a great deal; we only hope that he will not be disappointed. We must leave him to form his own judgment, as the questions raised are far too numerous and comprehensive to be profitably discussed within our necessary limits.

ACUTE ABDOMINAL DISEASES. (a)

In these days, when there appears to be no end to the writing of large text-books and lengthy monographs on isolated subjects, it is refreshing to meet with a small production in which a brave, and we may say a successful attempt, is made to bring into relation a large number of diseases which, though usually considered as separate and essentially different, have in reality many points in common, and probably

(a) "Clinical and Pathological Observations on Acute Abdominal Diseases." By Edred M. Corner, F.R.C.S., Surgeon to Out-Patients, Surgeon to the Physical Exercise Department, St. Thomas's Hospital, &c. Pp. 98. Price 3s. 6d. net. London: Archibald Constable and Co., Ltd. 1904.

spring from a similar, if not identical, cause. This Mr. Corner has done for all the acute infective diseases of the alimentary canal, and he has further shown a complete parallel to exist between the known septic diseases of the skin and those, largely unknown, of the mucous membrane of the alimentary canal.

The aim of the first part of the book is to prove that "Lesions of a similar nature, acute infective necrosis or gangrene, occur in the stomach, the duodenum, the small intestine, the cæcum, the appendix, the large bowel, Meckel's diverticulum, the gall-bladder, strangulated herniæ, and other forms of intestinal obstruction." The author starts by proving that necrosis of the bowel wall depends on two factors—first, the deprivation of the blood supply, and secondly, the infection of the tissues by septic micro-organisms. With the help of numerous cases which he quotes, he shows that the first of these factors is not so potent a one as it is usually supposed to be, owing to the fact that the anastomosis of the intestinal vessels is much greater than is generally thought, and that even if a medium-sized vessel is obstructed, the neighbouring blood-vessels are able to provide a sufficient blood supply to the area normally receiving its blood from the obstructed vessel; even if gangrene does occur in these cases it is limited to a smaller area and is of a subacute or chronic character. Infection with pyogenic micro-organisms on the other hand (which may be either preceded or followed by an anæmia from embolism or thrombosis of the vessels) causes an acute and wide-spread necrosis. This point is specially well brought out by a case which he relates: a male baby, two days old, was operated on for intestinal obstruction, a large meconium, containing Meckel's diverticulum was found, separated from the ileum by three complete twists, the bowel being occluded by the traction of the turns; the torsion must have begun in foetal life, but yet there were no signs of inflammation or necrosis in the cyst; as the meconium was sterile before birth, it was a very rare example of aseptic torsion of the bowel, and a vivid contrast to the usual acute infective necrosis of both diverticulum and bowel usually found in these cases occurring at a later period of life, when the intestinal contents are septic, two examples of which are given.

From this standpoint Mr. Corner gives a new classification of gastric ulcers—(1) Chronic cases, (2) acute cases: (a) acute ulceration or necrosis, which may be likened to a boil in the skin, owing to the thinness of the gastric wall the whole thickness is involved in the slough and a perforation results, as the area of infection is distinctly local and faecal there is little œdema or inflammation of the surrounding stomach wall, and closure by sutures is easy; (b) perforation may occur in but a part of a wider area of septic infection (like one of the many sinuses of a carbuncle), in this case the surrounding tissues are œdematous and inflamed, and suturing is difficult as the stitches tend to tear out. Another interesting point is well brought out in regard to intestinal suturing, as exemplified in the case of enterorrhaphy. The first row of sutures inserted through all the coats of the bowel, must cause necrosis of small portions of intestine by cutting off their blood supply, and are necessarily septic and therefore tend to cut their way out, therefore their use is to make a water-tight joint and prevent the access of septic organisms to the second or serous row of sutures, until the latter have caused a firm adhesion of the two portions of the intestine. Sepsis, therefore, rather than imperfections in stitching causes the failures of anastomosis.

In a section entitled "The Physical Physiology of the Alimentary Tract and Appendicitis," the author says that when the food reaches the ileo-cæcal valve, "it is the duty of that sphincter only to allow water and indigestible *debris* to enter the cæcum." If this is the case, how does he explain the wasting and marked deterioration in health that undoubtedly occurs in cases where an artificial anus is made in connection with the cæcum or commencement of the ascending colon? Though owing to the muscular fibres surrounding the

ileo-cæcal orifice, there may be a slight sphincteric action which prevents the too rapid entrance of the contents of the small intestine into the large, yet surely the main office of this valve is to prevent regurgitation from the large bowel into the small.

The latter part of the book is taken up with the bacteriology of the "Acute Infective Necroses." In this Mr. Corner states very forcibly his opinion that pyogenic micro-organisms are at the root of all these troubles, and that the bacillus coli communis is a much maligned "bug." He explains the frequency of the latter bacillus and the rarity of the former in cultures taken from cases of peritonitis following these acute necroses, by the fact that the bacillus is very easily grown on ordinary media and is a much more luxuriant and hardy grower than the pyogenic cocci, the proof of this being commonly seen in laboratory experiments where the bacillus either obscures or even stops the growth of staphylococci and streptococci. By reference to statistics he shows that the more acute the infection is, as seen in cases of appendicitis, the more frequently are pyogenic organisms found in the peritoneal exudate. Therefore it is probable that even in cases where only the bacillus coli communis is isolated, the pyogenic cocci have first been at fault, but their misdeeds have been obscured by the excessive zeal of the bacilli, which receive the blame. The following sentence sums up the latter portion of the book:—"I believe that we must look to pyogenic micrococci for the starting point of cases of acute perforation and gangrene—i.e., acute infective necrosis, in whatever part of the alimentary tract it may be situated."

Literary Notes and Gossip.

THE *British Journal of Inebriety*, the official organ of the Society for the Study of Inebriety, occupies a unique position among scientific journals. It is a medico-sociological review, which deals with the Alcohol Problem mainly in its biological aspects. The January number contains suggestive notes by Dr. Harry Campbell, on the Drinks of the Early Agriculturists. Dr. C. F. Harford writes on the drinking habits of uncivilised and semi-civilised races. The Pathology of Chronic Alcoholism is discussed by Dr. Ford Robertson, and Dr. Claude Taylor deals with the Pauper Inebriate. The Editor, Dr. T. N. Kely-nack, has an opportune article on the recently issued Report of the Inspector under the Inebriates Acts. The journal is one which should be studied by all interested in the evolution of the human.

MESSRS. LONGMANS have in the Press, under the title of "'N' Rays: A Collection of Papers communicated to the French Academy of Sciences, with additional Notes and Instructions for the Construction of Phosphorescent Screens," by R. Blondlot, Professor in the University of Nancy. Translated by J. Garcin. "N" Rays, discovered by Professor Blondlot, are a peculiar kind of rays emitted by a Crookes' tube, a Nernst lamp, the sun, and many other sources. Their properties, an account of which is the subject of this volume, are quite distinct from those of "X" or Röntgen Rays, and from those emitted by radio-active bodies like radium and uranium.

ON the literary horizon of the New Year has appeared the ninth edition of that popular text-book, "The Diseases of Women and Uterine Therapeutics," by Dr. Macnaughton Jones, with many new plates, and much new material in the text. The seventh edition of Delafield and Prudden's "Text-Book of Pathological Anatomy and Histology" is also before us with a large number of new illustrations, and Erlich's "side-chain" hypothesis has been herein set forth with considerable detail. We have also received a large, and what promises to be an important, treatise on "The Preparation and After-treatment of Section Cases," by Dr. Stewart McKay, of Sydney. The author assisted the late Mr. Lawson Tait in many of his operations, and is imbued with the spirit of the

master. Although now resident in the Antipodes, where, it is understood, he enjoys an extensive surgical practice, he is not unknown in medical literature in this country, where he has published, through Messrs. Bailliere, Tindall, and Cox, an interesting work on "The History of Ancient Gynæcology," and one on Lawson Tait's "Perineal Operations." His new volume is prefaced with a commendatory note by Mr. Christopher Martin, of Birmingham. From Messrs. Wright and Co., of Bristol, we have received another book by Dr. Fernie, entitled "Meals Medicinal," in which he has incorporated the main portions of his former popular little work on "Herbal Simples."

THE *Westminster Review* of January, which has now entered its eighty-second year, shows no sign of decrepitude in the vigorous and interesting articles that go to make up an excellent number. The subjects herein dealt with of special interest to medical men are:—"Behind the Mask," by Chas. Rolleston, a very vigorous and logical essay on hospital administration, in which the writer maintains that many of these institutions "deserve to be prosecuted for obtaining money under false pretences"; and a historical survey of old and new methods in "London Water Supply," by W. J. Fisher. The publication of the *Review* has now been transferred to Messrs. Marlborough and Co., London.

Nor many publishing houses can boast a century of existence. In an interesting brochure before us, Messrs. William Wood and Company, the leading medical publishers of New York, trace the history of their establishment from 1804, when it was founded by Mr. Samuel Wood, to the present time, the firm now consisting of the founder's grandson, Mr. William H. S. Wood, and his three sons. During this period many monumental works have been published by them, notably Ziemssen's "Cyclopædia of the Practice of Medicine," in twenty-two royal octavo volumes, and the "Twentieth Century Practice of Medicine," in twenty volumes, edited by Dr. J. L. Stedman, completed in 1901. The little brochure is published with portraits of the founder and subsequent members of the firm, affording an interesting comparison in costume and personal appearance between 1804 and 1904.

THE MOST COMPLICATED SURGICAL CASE ON RECORD.

THE following narrative by a hospital surgeon, which a correspondent of *The Daily News* vouches to have taken *viva voce* in an interview, is too good to be passed over:—

"What is the most complicated surgical case I can call to mind? Ah! that is indeed a question! I don't know, though, that there's any doubt about it really, when I come to think of it. Captain Castagnette's is the classical case. I'll describe it in un-technical language. He was one of Napoleon's veterans, who began as a private soldier under the Committee of Public Safety. He lost an arm at Valmy. Good soldiers were not discouraged in the straits in which France then was, and he was soon in the field again, but lost a leg at Wattignies. Nothing daunted, Castagnette returned to active service in time to have his face shattered by a shell at Rivoli. It was replaced by a waxen mask; but he went on the Egyptian campaign; the sun melted it, and Napoleon presented him with a silver one.

"He got off without much more serious knocking about until the battle of Jena, when he received a grapeshot in the stomach, which had to be cut away and replaced by a leather one. At Wagram a small shell lodged in the middle of his back. It did not explode, and it could not be removed, in the existing state of surgical science, without danger to Castagnette's life. They left it where it was.

"He went on the fatal march to Moscow, and his leather stomach, which was less exigent in its demands than an ordinary one, was most useful to him in the terrible privations of the retreat. At Leipsig

Castagnette lost his remaining leg and arm, and gained the Cross of the Legion of Honour.

"In 1815 he rejoined the Emperor on the return from Elba, and fought at Waterloo. He had two wooden legs and a helmet with a long spike on it, an idea borrowed from the rhinoceros at the Jardin des Plantes. With this he did some execution, but was struck down and left for dead on the field.

"It was his last battle. Yet it was at the hands of the enemy that he died at the Invalides, fifteen years later. He fell asleep in front of a fire, and his wooden legs became ignited. Slowly the fire crept up, until his leathern stomach began to smoulder. All this time he had, of course, felt nothing; and he never felt anything again, for before he awoke the shell in his back exploded with a deafening report. The only recognisable thing found in the room afterwards was the Cross of the Legion of Honour, which Castagnette had been wearing."

NEW BOOKS AND NEW EDITIONS.

The following have been received since the publication of our last list:—

- BAILLIÈRE, TINDALL AND COX (London).**
The Problem of the Milk-Supply. By F. Lawson Dodd, M.R.C.S., L.R.C.P., &c., &c. Pp. 77. Price 1s. 6d. net.
- Walsham's Handbook of Surgical Pathology: for the Use of Students in Pathology. Third Edition, revised and largely rewritten by Herbert J. Paterson, M.A., M.B., &c., &c. Pp. 529. Price 10s. 6d. net.
- Practical Manual of Diseases of Women and Uterine Therapeutics for Students and Practitioners. By H. Macnaughton-Jones, M.D., M.Ch. Ninth Edition. University Series. Illustrated. Pp. 637. Price 21s. net.
- Some Methods of Hypodermic Medication in the Treatment of Inoperable Cancer. By John A. Shaw-Mackenzie, M.D. Lond. Pp. 32. Price 1s. net.
- The Treatment of Syphilis. By F. J. Lambkin, Lieut.-Col. R.A.M.C., Specialist at Army Headquarters, India. Pp. 160. Price 3s. net.
- The Preparation and After-treatment of Section Bases. By W. J. Stewart McKay, M.B., M.Ch., B.Sc. Illustrated. Pp. 65r. Price 15s. net.
- A Handbook of Pathological Anatomy and Histology. By Francis Delafeld, M.D., LL.D., and T. Mitchell Prudden, M.D., LL.D. Seventh Edition. Illustrated. Pp. 886. Price 25s. net.
- A Manual of Toxicology. By Albert H. Brundage, A.M., M.D., Ph.D. Fourth Edition. Revised and Profusely Illustrated. Pp. 401. Price 8s. 6d. net.
- JOHN BALE, SONS AND DANIELSSON, LTD. (London).**
The Simple Medical Year-Book or Private Medical Ledger. Price 10s. 6d. net.
- The Ambulance in Civil Life and the Proceedings of the Metropolitan Street Ambulance Association. By Reginald Harrison, F.R.C.S. Pp. 70.
- ADAM AND CHARLES BLACK (London).**
Who's Who, 1905. Pp. 1,796. Price 7s. 6d. net.
- Who's Who Year-Book for 1905. Pp. 128. Price 1s. net.
- The Englishwoman's Year-Book, 1905. Seventh year of new issue. Edited by Emily James. Twenty-fifth year. Pp. 368. Price 2s. 6d. net.
- WILLIAM BLACKWOOD AND SONS (Edinburgh).**
Practical Nursing. By Isla Stewart, Matron of St. Bartholomew's Hospital, London, and Herbert E. Cuff, M.D., F.R.C.S. A New Edition. Pp. 436. Price 5s. net.
- J. AND A. CARUCCI (London).**
Reports of the Society for the Study of Disease in Children. Vol. IV. Session of 1903-4. Edited by George Carpenter, M.D. Pp. 378. Price 12s. 6d.
- Year-Book of Pharmacy and Transactions of the British Pharmaceutical Conference, 1903-4. Edited by J. C. Braithwaite, E. Saville Peck M.A., and Edmund White. Pp. 641.
- EVRE AND SPORTSWOODS (London).**
Statistical Report of the Health of the Navy for the Year 1903. Pp. 217. Price 4s. 9d.
- WILLIAM GREEN AND SONS (London).**
Manual of Antenatal Pathology and Hygiene: the Embryo. By J. W. Ballantyne, M.D., F.R.C.P.E., F.R.S. Edin. Pp. 697. Price 21s. net.
- HOSSEY AND GILLINGHAM (Adelaide).**
A Manual for Coroners. By W. Ramsay Smith, M.B., B.Sc. Edin, City Coroner for Adelaide. Pp. 153. Price 10s. 6d. net.
- HENRY KIMPTON (London).**
Diseases of the Heart. By Edmund Henry Colbeck, B.A., M.D., &c., &c. Second Edition. Revised, enlarged and illustrated. Pp. 350. Price 7s. 6d. net.
- H. K. LEWIS (London).**
Landmarks and Surface Markings of the Human Body. By Louis Bathe Rawling, M.B., B.C., &c. Illustrated. Pp. 76. Price 5s. net.
- J. B. LIPPINCOTT COMPANY (London).**
International Clinics: a Quarterly. Edited by A. O. J. Kelly, A.M., M.D., &c. Volume III. Fourteenth Series, 1904. Pp. 500. Price 10s. 6d.
- LONGMANS, GREEN AND CO. (London).**
Transactions of the Clinical Society of London. Vol. 57. Pp. 473. A Text-Book of Medical Practice for Practitioners and Students. Edited by William Bain, M.D., M.R.C.P. Illustrated. Pp. 1,011. Price 25s. net.

THE MEDICAL TIMES, LTD. (London).

The Chief Operations of Ophthalmic Surgery: a Practical Guide for Students. By Harold B. Grimsdale, M.B., B.C., F.R.C.S. Pp. 144. Price 5s.

GEORGE A. MORTON (Edinburgh).
Ombra the Mystery. By Frederick Graves. Pp. 337.

REEMAN, LTD. (London).

An Atlas of Human Anatomy for Students and Physicians. By Carl Toldt, M.D., assisted by Prof. Rosa, M.D. Translated by M. Edeu Paul, M.D. Bruz., &c., &c. Sixth Section: (G) Neurology, (H) The Organs of the Senses. Pp. 239. Price 16s. 6d. net.

W. B. SAUNDERS AND CO. (London).

Gall-stones and their Surgical Treatment. By B. G. A. Moynihan. M.S. Lond., F.R.C.S. Illustrated. Pp. 386. Price 17s. net.

JOHN WRIGHT AND CO. (Bristol).

Diseases of the Ear for Practitioners and Students of Medicine. By James Kerr Love, M.D. Illustrated with Fifty-Four Stereoscopic Photographs. Pp. 330. Price 23s. net. Stereoscopes 2s. and 2s. 6d. post free.

Meals Medicinal, with "Herbal Simples" (of Edible Parts). By W. T. Fernie, M.D. Pp. 781. Price 9s.

Obituary.

DR. WM. MORGAN, OF NEWPORT.

Dr. William Williams Morgan, who died at Newport on Saturday at the age of ninety-five, was reputed to be the oldest medical practitioner in the country. Born at Merthyr, he was educated at Aberaeron and at Guy's and the London Hospitals. He took the diplomas in 1835 of M.R.C.S. Eng. and L.S.A., and commenced practice at Newport, where he had ever since resided. Soon after his arrival there he was present at the Chartist riots in the town, which resulted in eleven men being killed. He heard the firing, and tended the wounded where they fell, at the risk of his own life. Dr. Morgan was a personal friend of John Frost, the leader of the Chartist movement in South Wales, who was sentenced to death for his share in the riots, but was respited and transported. His death removes a well-known and highly respected personality from Wales.

DR. THOMAS WOODS, OF BIRR.

It is only a few months since we recorded the retirement from his Poor-law appointment of Dr. Thomas Woods, whose death we now regret to announce. Dr. Woods became a member of the Royal College of Surgeons of England in 1838, and was engaged in the practice of the profession from that time until a few weeks before his death. For over sixty years—since the early 'forties—he was dispensary doctor of Birr, and during the whole of that time no complaint was ever lodged against him. Beside being a successful and beloved practitioner, he was a man of wide interests and reading in science and philosophy. He took an active part with the late Lord Rosse in the construction of the huge telescope which for many years was the largest in the world, and he wrote a book in description of it. Of many other published works, his most considerable was a vigorous and trenchant criticism of the theory of evolution.

DR. WILLIAM CARMICHAEL, OF EDINBURGH.

The death of this gentleman on the last day of the old year came as a severe blow to an unusually large circle of patients and friends. He had gone to London to recruit after an attack of influenza, when pneumonia set in, and he succumbed after a short illness. Dr. Carmichael had been established in practice in a southern suburb of Edinburgh for about twelve years, and was greatly and deservedly respected in the district and beloved by his patients. He was a man of the most sterling worth, absolutely untiring in his devotion to his profession, and without any thought of himself where his patients were concerned. His loss leaves a blank in the lives of many, and his place will be long in being filled. He leaves behind him the memory of an ideal doctor and an honest, upright, Christian gentleman.

DR. J. W. W. PENNY, PORT BANNATYNE, BUTE.

We regret to announce the death of Dr. Penny, Prospect House, Ardbeg, after a very protracted illness, and at the comparatively early age of forty years. He

had been incapacitated from professional work for a considerable period. He was very popular, and his death will be deeply mourned by the people of the island. A younger brother, Dr. David Penny, practises in Rothesay.

JAMES MUNRO, M.D.ED., L.R.C.S.ED., OF DARLINGTON.

DR. JAMES MUNRO, J.P., died on the 4th instant, apparently from heart failure, at the age of 70. The deceased gentleman, who was one of the best known in the town and district, was in his usual state of health on the previous night, and about midnight was preparing to retire to his room, when he became ill. Assistance was soon forthcoming, but he died within a few minutes. The deceased was a native of Scotland, and studied for the medical profession at Edinburgh, where he took the M.D. in 1882, and the L.R.C.S. in 1880. At the time of his death he was Surgeon-Lieutenant-Colonel of the Barnard Castle Militia regiment.

JOHN BOWIE, L.R.C.S., L.R.C.P.EDIN.

MR. JOHN BOWIE died at his residence in Lauriston Place, Edinburgh, on Jan. 3rd, at the age of seventy-three years. Mr. Bowie, who was born at Edinburgh, early evinced a strong desire to enter the medical profession. Pushing his studies in that direction, he soon took a prominent place as assistant to the late Dr. Handyside, and on the death of that gentleman he became chief demonstrator to Sir William (then Professor) Turner. His tastes, however, not lying in that direction, he took up general practice, though urged to adopt anatomy as a speciality. He was much esteemed by a large circle in the city. He is survived by two daughters and four sons, two of the latter being engaged in the medical profession in London. He was educated in Edinburgh, and took the L.R.C.S. and P. Diploma in 1866.

HENRY WILSON, M.D.ST. AND., M.R.C.S.ENG., L.S.A.

THE sudden death is announced of Dr. Henry Wilson, M.R.C.S., L.S.A., of 22, High Street, Waverley, on the 1st instant. Well-known and highly respected in the district, his death will be much regretted. His medical education was conducted at Anderson's College, Glasgow. He qualified as M.R.C.S. in 1868 and M.D. St. And. 1890.

JAMES DOW SAINTER, F.R.C.S. Ed., M.R.C.S. ENG.

WE regret to announce the death at Craigellachie, Banffshire, of Brigadier-Surgeon James Dow Sainter. He was born in 1835, and after finishing his education at the King's School, Macclesfield, studied for the medical profession at the Manchester Royal Infirmary. In 1859 he joined the Army as an assistant surgeon, and he served with the Cavalry Division throughout the campaign of 1860 in China. After a short spell of home service he was ordered to India, and served there, with short intervals in England, until 1877, when he returned home. He was stationed in Manchester until he retired from the Army in 1880.

GEOFFREY EDWARD HALE, M.B.CAMB., OF ETON.

DR. GEOFFREY EDWARD HALE died last Saturday at his house in High Street, Eton, from scarlet fever, caught from a patient, which brought on septic pneumonia. Dr. Hale, who was the eldest son of the late Rev. E. Hale, was educated at Eton, Cambridge, and St. George's Hospital. He took the M.B. and B.C. degrees at Cambridge in 1891, and at St. George's Hospital he won a scholarship and the Acland and Treasurer's prizes, and held staff appointments. At one time he was assistant demonstrator in anatomy and physiology at Cambridge, and contributed on technical subjects to the *British Medical Journal*. Dr. Hale had many friends among the masters and

boys at Eton, where his patient and skilful attendance on all classes and his disinterested sympathy with the poor were highly appreciated. He married in 1894 the eldest daughter of Canon Kynaston, of Durham.

Medical News.

Fire at a County Asylum.

EARLY on the morning of the 9th instant, a disastrous fire broke out in the Bucks County Asylum Stone. The outbreak was discovered by a nurse who was returning from night duty and heard the sound of crackling wood. She at once summoned help and all the inmates were removed to a place of safety. The damage to property was great, but fortunately there was no loss of life. The happy result was clearly in great measure due to the presence of mind of the night nurse, whose name we hope to give in our next issue.

Copyright in Cancer Cinematograms.

SOME years ago Dr. Doyen had cinematograph reproductions made of some operations he performed, these pictures being used for lectures both in France and abroad. It has recently transpired that copies were made and sold to various people, some of whom reproduced life-like pictures of the operations in theatres and booths. Dr. Doyen is reported to be now bringing an action for 200,000f. against the manufacturers, claiming that the pictures are his property.

Proposed Sanatorium at Davos.

LORD BALFOUR OF BURLEIGH presided on Jan. 4th, over a public meeting of English speaking visitors and residents at Davos, held in connection with the proposed Queen Alexandra Sanatorium at Davos for sufferers from tuberculosis who are possessed of only limited means. The first annual report of the Council shows that subscriptions up till June 15th last, amounted to £6,367 19s. 1d. After payment of all expenses to date, including £2,918 towards the purchase of a site, a sum of £2,981 remains in hand.

Death from Hydrophobia.

A REUTER telegram from Victoria (B.C.), of January 3, states that Mr. James Colevin, a prominent shipbuilder of Victoria, who was bitten by a wolf in September, has just died of hydrophobia. This is the first recorded case of hydrophobia in British Columbia.

Radium and Granular Lids.

FROM Berlin it is reported that the ophthalmologist, Professor Herman Cohn, of Breslau, has succeeded in healing granulations of the eyelids with radium. He adds that as yet he has had only three cases of cures, but they were all cases in which other methods had failed, in spite of several months' treatment. Professor Cohn treats each single granulation with the radium, which, for this purpose, is contained in a glass tube. He suggests making extensive experiments in Egypt, where diseases of the eye are so widespread.

Serum Treatment of Anthrax in Worcestershire.

AN important and successful experiment has been made at Kidderminster Infirmary with the serum for the treatment of anthrax. Professor Scavo, of the Institute of Experimental Hygiene of the University of Siena, discovered the value of the serum in question in the course of his experiments, and the attention of our Home Office was drawn to the subject. Dr. Legge, of the Home Office, after visiting Italy, obtained some of the serum, and part of it was sent to Kidderminster Infirmary. Here it has just now been put to a practical test. A patient was admitted to that institution on December 23rd suffering from anthrax. The serum treatment was adopted, and the result is that the patient was sufficiently well to be discharged in eight or nine days. So far as is known, Professor Scavo's serum has only been used in one other case up to the present in this country, and the success which has attended its use in the case which has just occurred in Kidderminster points to it being found a most valuable curative for an extremely malignant disease.—*Standard*.

Notices to Correspondents, Short Letters, &c.

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

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.

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 re-forwarding 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.

A. K. S. (Surbiton).—Progressive tuberculosis of the lungs is always accompanied by pleurisy. So far your critic is correct. Pleurisy may, however, as everyone knows, be non-tuberculous. In a young adult, unless the cause be adequate and obvious pleurisy and empyema should always be regarded with suspicion, especially if there be a family history of consumption. Send some of the aspirated fluid to a research laboratory to be examined for tubercle.

J. J. THOMSON (Leeds).—We do not know any book that quite fills the gap you mention in medical literature. You should write the MS. to a medical publisher, or if you have not reached that stage, write for advice on the subject.

PUBLIC HEALTH STUDENT.—You should read an excellent paper on the subject of preservatives in milk recently presented to the Essex County Council by Messrs Bernard Dyer and T. S. Dymond. In the course of that article they quote authorities as agreeing in condemning the recommendation of the Departmental Committee on Food Preservatives, with regard to milk. They were all distinctly of opinion that milk containing boric acid, formalin or any other preservative was to be regarded as not of the nature, substance, and quality of genuine milk, and that cases of the kind should be dealt with accordingly.

DR. SHAW MACKENZIE.—We hope to have space for your communication in our next.

MR. J. A. R.—The communication and the accompanying letter have different signatures, kindly explain.

DR. LAFFOON SMITH (Montreal).—Your paper is marked for early insertion.

J. C. R.—Is thanked for his appreciative note and generous tribute to our efforts which we can promise will not be relaxed.

EDINBURGH STUDENT.—A recently issued little book entitled "Medical Laboratory Methods and Tests," by Dr. Herbert French Medical Registrar of Guy's Hospital, would we think exactly meet your requirements.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JANUARY 11th.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus, E.C.). 9 p.m. Mr. R. Godlee: Shifting Dulness and its bearing on Surgical Conditions. (Hunterian Lecture.)

DERMATOLOGICAL SOCIETY OF LONDON (11 Chandos Street, Cavendish Square, W.).—5.15 p.m. Demonstration of Cases of Interest.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (23 Chenies Street, W.C.).—4 p.m. Mr. J. Clarke: Clinique. (Surgical.) 5.15 p.m. Dr. J. E. Squire: The Elements of Prognosis in Pulmonary Tuberculosis.

THURSDAY, JANUARY 12th.

BRITISH GYNECOLOGICAL SOCIETY (20 Hanover Square, W.).—3 p.m. Specimens will be shown by Dr. G. Elder and Dr. I. Parsons The President: Valedictory Address.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Titchborne Street, Edgware Road, W.).—8 p.m. Smoking Concert.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC, 23 Chenies Street, W.C.—4 p.m. Mr. Hutobinson: Clinique. (Surgical.) 5.15 p.m. Mr. A. H. Tabby: Orthopaedic Surgery.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Mr. Cantlie: Beri-Beri.

FRIDAY, JANUARY 13th.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8.30 p.m. Papers: Dr. T. J. Walker (introduced by Prof. H. Marsh): Acute Ascending Paralysis in Cases of Chronic Cystitis.—Mr. B. O. Lucas: A Case of Accidental Electrocutation causing extensive Gangrene of all the Extremities.—Dr. W. Ewart: A Case of "Soft Valve" Mitral Stenosis in which no Murmur was heard.

LARYNGOLOGICAL SOCIETY OF LONDON (20 Hanover Square, W.).—4.15 p.m. Annual General Meeting. 5 p.m. Ordinary Meeting. Cases, &c., will be shown by Dr. St. Clair Thomson, Mr. P. de Santi, Dr. H. Tilley, Sir F. Semon, Dr. F. Powell, and others.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (23 Chenies Street, W.C.). 4 p.m. Dr. D. Grant: Clinique. (Ear).

BRITISH ENTOMOLOGICAL, LARYNGOLOGICAL AND OTOLOGICAL ASSOCIATION (11 Chandos Street, W.).—4 p.m. President's address. Paper by J. Sim Wallace. Cases will be shown by the President, Mr. O. Nourse, Dr. Kelson, Dr. Jakins, Dr. Wyatt Wingrave, Dr. McKenzie.

TUESDAY, JANUARY 17th.

THE MEDICO-LEGAL SOCIETY (The Royal Asiatic Society's Rooms, 23 Albemarle Street, W.).—8 p.m. A Case of disputed Fracture of the Clavicle, by Dr. J. G. Garson. Demonstration: The Development of Invisible Finger-prints, by Dr. J. G. Garson. Discussion: The Law relating to the Criminal Responsibility of the Insane, to be opened by A. Douglas Cowburn, Esq.

Vacancies.

King Edward VII. Sanatorium.—Medical Superintendent. Salary £500 per annum, with board, lodging, and attendance. Applications to the Secretaries, 19 Devonshire Street, Portland Place, London, W.

Royal South Hants and Southampton Hospital.—House Surgeon. Salary £100 per annum, with rooms, board, and washing found. Applications to T. A. Fisher-Hall, Secretary.

Ashton-under-Lyne District Infirmary and Children's Hospital.—Resident House Surgeon. Salary £120 per annum, with board, washing and lodging, gas, firing, and attendance. Applications to the Honorary Secretary, Leonard Bottomley, 100 Stamford Street, Ashton-under-Lyne.

Ingham Infirmary and South Shields and Westoe Dispensary.—Senior House Surgeon. Salary £100 per annum, with residence board, and washing. Applications to James E. Wheldon, Secretary, 74 King Street, South Shields.

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

East Sussex District Asylum, Hellingly.—Senior Assistant Medical Officer. Salary £300 per annum, with board, lodging, washing, and attendance. Applications to Reginald Blaker, Clerk to the Visiting Committee, 211, Higher Street, Lewes.

Chester General Infirmary.—House Surgeon. Salary £100 per annum, with residence and maintenance in the house. Applications to the Chairman of the Board of Management.

New Zealand.—Professor of Physiology at the University of Otago. Salary £600 per annum, with half of the Class Fees. Application to the Agent-General for New Zealand, 13 Victoria Street, London, S.W.

Derbyshire Royal Infirmary.—House Surgeon. Salary £100 per annum, with apartments, board, &c. Applications to Walter G. Carnit, Secretary-Superintendent, Royal Infirmary, Derby.

Derbyshire Royal Infirmary.—House Physician. Salary £100 per annum, with apartments, board, &c. Applications to Walter G. Carnit, Secretary-Superintendent, Royal Infirmary, Derby.

Derby.—Medical Officer for High Class Sanatorium, unmarried, with capital, must take half share interest with owner. Applications to C. 43 Howard Street, Derby. (See Advt.)

Appointments.

HAY, A. G., M.D. Glasg., Certifying Surgeon under the Factory Act for the Maryhill (Glasgow) District of the county of Lanark.

JAMIESON, J. W. M., M.B., Ch.B. St. And., Physician to the Dundee, Royal Infirmary.

SADLER, E. A., M.D. Lond., Certifying Surgeon under the Factory Act for the Ashbourne and Mayfield District of the Counties of Derby and Stafford.

Births.

ARMOUR.—On January 6th, at 89 Harley Street, W., the wife of Donald John Armour, M.B., F.R.C.S., of a daughter.

Marriages.

BRAY-LAFFAN.—On January 4th, at St. Mary's Church, Holyhead Major George A. T. Bray, R.A.M. Corps, second son of the late Major-General F. C. Bray, (96th), to Angela, daughter of Dr. Thomas Laffan, of Cashel, co. Tipperary.

CAMPBELL-TAIT.—On January 7th, at St. Mark's, North Audley Street, London, W., Robert Brown Campbell, M.B., Physician, Superintendent, District Asylum, Inverness, to Margaret Amelia, only daughter of William Tait, M.V.O., Windsor.

HART-GUY.—On December 14th, 1904, Herbert Frere Hart, M.B., late R.A.M.C., second son of Colonel E. C. Hart, late Royal Engineers, to Violet May, second daughter of Mr. and Mrs. Gustave Guy, of Groenloof, Fauremuth, Orange River Colony.

TAYLOR-BAKER.—On January 6th, at St. Stephen's, Baywater, William Henry Maxwell, M.A., M.B. Camb. F.R.C.S. Eng., son of the late William Maxwell of Blackheath, to Gladys Dyer, daughter of the late Herbert H. C. Baker, of King William's Town.

Deaths.

BLACKETT.—On January 5th, at his residence, 41 Cambridge Street, London, W., Joseph Bryon Blackett, M.B. C.S., aged 80 years.

BLOMFIELD.—On January 6th, at 20 Peckham Road, Josiah Blomfield, M.D. F.R.C.S., late of Rye Lane, in his 82nd year.

HENDERSON.—On January 4th, at Fordoun House, Waltham Abbey, John Brodie Henderson, M.D., aged 61.

ROBINSON.—On January 4th, at 3 Windsor Terrace, Jersey, Louisa Robinson, daughter of the late Dr. Isaac Robinson, Deputy Inspector, General Medical Staff, aged 67.

STOLTERFOTH.—On January 7th, at 1 Grey Friars, Chester, Maria Augusta Stolterfoth, eldest and last surviving daughter of the late Sigismund Stolterfoth, M.D.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXX.

WEDNESDAY, JANUARY 18, 1905.

No. 3.

Paris Clinical Lectures.

THE SURGICAL TREATMENT OF FACIAL PARALYSIS.

By FRANCIS MUNCH, M.D.,

Of the Faculty of Medicine of Paris.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

LONG regarded as an affection amenable exclusively to medical treatment, facial paralysis during the last few years has, little by little, fallen into the hands of the surgeon. We hasten to add, however, that it is not claimed that surgical intervention can usefully be invoked in all cases of facial paralysis. It is not proposed to add one more to the list of affections taken from the domain of medicine in favour of more drastic methods. The surgeon merely places the resources of his art at the disposal of patients whose affection has hitherto been regarded as incurable, their treatment having proved refractory to all means at present at the disposal of medical therapeutics. The surgeon thus merely completes the work of the physician, and his intervention, far from taking the place of medical treatment, commences where that ends, in other words, it merely enlarges the domain, and widens the horizon, of curative therapeutics.

The operation proposed in view of the treatment of facial paralysis consists in establishing an anastomosis of the paralysed facial nerve and a neighbouring cranial nerve. The first recorded operation of the kind was performed by Dr. J. L. Faure, on the suggestion of Dr. Furet, in 1898, but it had already been performed by Mr. Ballance in England in 1895. In any event, Faure's proposal found little favour in France, for out of twenty-two observations which I have been enabled to bring together only one is credited to a French surgeon. In most of these cases the intervention comprised a spino-facial anastomosis, the peripheral end of the facial nerve, divided at its point of exit from the stylo-mastoid orifice, was joined in one way or another with the external branch of the spinal nerve or with the branch from this nerve to the trapezius. In seven cases the anastomosis was between the facial and the hypoglossal nerve. The glosso-pharyngeal nerve has also been recommended as an alternative by Schäffer, of Edinburgh, but although the latter operation presents certain advantages from the functional point of

view, its execution is so complicated that few surgeons are ever likely to avail themselves thereof.

The first question we have to ask ourselves is whether the proposed operation is rational. Is the facial graft legitimate in the light of our present physiological knowledge, and is it likely to attain the object in view? In the light of current physiological views we may assume that section of a motor nerve is followed by loss of excitability on the part of the peripheral end, which undergoes what is known as Wallerian degeneration. About thirty days after section of the nerve all that remains is the white matter of Schwann studded with nodules embedded in dried protoplasm. The changes bear on the entirety of the distal segment. The central part, on the contrary, remains intact. The extremity of the axis cylinder becomes slightly swollen, constituting a sort of "zone of growth," which subsequently extends by development of the axis cylinder. If the ends of the divided nerve have been brought together after division the axis cylinder granulates until it reaches the peripheral end, insinuates itself in the old Schwann's layer, and thus nervous continuity is restored.

It would seem, therefore, that anastomosis of the central end of an undamaged nerve with the peripheral end of a paralysed facial nerve, followed by its regeneration, is a perfectly admissible fact from a histo-physiological point of view, at any rate in principle. We must not overlook the fact, however, that in facial paralysis of the third degree, that is to say, the very cases which are reputed to be medically incurable and therefore fall into the surgical domain, can only be identified as such after the lapse of a variable length of time. Whatever the delay, it must necessarily be of considerable duration, and in virtue of the principles enunciated above we must obviously abandon the hope of inducing the "zone of growth" of the central nerve to develop a connection with the fibrous remains which is all that is left of the peripheral part of the facial nerve. For this reason we are unable to attach much importance to the researches undertaken by Manasse and Barago-Clarella in experimental spino-facial anastomosis. In these experiments indeed, the anastomosis was invariably effected immediately after section of the nerves, and they teach us little with regard to the point under consideration, *viz.*, whether, in a grave and therefore ancient case of facial paralysis, we have any chance of obtaining nervous regeneration. These researches, moreover, add nothing to the knowledge already obtained by experiments long since carried out by Philippeaux and Vulpien on the crossed suture of the hypoglossal and lingual, &c., investigations

which conclusively settled the point under discussion without leaving the slightest doubt as to the reality of the fact, *per se*, or on the possibility of the functional restoration after similar nervous conjunctions.

The histological researches carried out by Stewart, at the suggestion of Mr. Ballance, present, from the point of view of spino-facial anastomosis, a vastly greater importance. On the strength of a series of histological researches, both experimental and clinical, these authors were led to conclude, in opposition to the generally received view, that the axis cylinder is in nowise derived from a cellular body situated in the neuraxis or in the spinal ganglia. There is no question of prolongations derived from medullary neuroblasts insinuating themselves in the tissues to reach their muscular or cutaneous termination. According to Messrs. Ballance and Stewart, the axis cylinder is constituted by the fusion of an infinite number of segments. Each of these segments is built up of special cells, which play their part in the structure of the nerve sheaths, the nucleus whereof is attached to Schwann's sheath. In the interior of these cells, Messrs. Ballance and Stewart have witnessed the appearance, some time after division of a nerve, of various elements which subsequently provide, some of them myosine, some a segment of axis cylinder. When the peripheral end of the nerve is not united to the segment that has remained in connection with its trophic centre, these changes soon cease to take place—there is no "maturation." But if union be brought about, the fragments of axis cylinder become fused together and penetrate and traverse the sutures restoring connection with the central end.

It will be seen that this process differs greatly from the classical procedure. The peripheral segment plays an active, indeed a predominating, rôle in the regeneration of the nerve; moreover, the nerve cell, *per se*, no longer occupies the all-important position in the process of repair formerly attributed to it. The axis cylinder is relegated to the simple position of an offshoot of the nerve cell, being made up of the fusion of numerous segments, derived each from a different and non-central cell.

However this may be, the most important conclusion to be drawn from the researches of the English observers is, that the peripheral segment of a nerve, even though it has undergone complete degeneration, after months or even years, although it has become reduced to a mere fibrous cord, preserves, nevertheless, Schwann's nuclei, which remain capable of renewed activity and enable the damaged nerve to become once again a conductor of nervous energy, provided it be linked up with the central segment of another nerve. It follows that the vitality of the nerve is not the point to be considered, since it is assured; it is, indeed, the state of the muscle that should occupy our attention, for upon its contractility will depend, in great measure, the result of our intervention. Obviously, if the contractility of the muscle is lost no nerve suture can be of service; in short, in discussing the propriety of an intervention it is to the muscle rather than to the nerve that we must look.

Most operators now adopt Faure's suggestion to make use of the spinal nerve for the purpose of suture with the degenerated facial nerve. It is important to divide the facial as close as possible to

the stylo-mastoid foramen in order to bring as long a segment of degenerated nerve within the sphere of influence as possible. The simplest plan in regard to the spinal nerve is to make use of the branch to the trapezius, which can easily be isolated at the spot where it enters the body of the muscle through which it has to pass. Some surgeons practise the anastomosis end-to-end, others lateral anastomosis, as, for instance, in the method adopted by Ballance, who splits the sheath of the spinal nerve by a small incision, into which he inserts the end of the facial. This procedure has the advantage of avoiding the paralysis of the mastoid and trapezius, and experience does not show any subsequent dragging thereon. Dr. Faure selected the spinal nerve in preference to the hypoglossus and glosso-pharyngeal, on the ground that it necessitated less manipulation. It must, however, be borne in mind that the destruction of the spinal nerve necessarily entails atrophy of the shoulder muscles with consequent paralysis. Moreover, the spino-facial anastomosis, when successful in restoring contractility of the facial muscles, determines synergical contractions in the shoulder, so that voluntary or involuntary contraction of the shoulder muscles is associated with corresponding contraction on that side of the face. Now the contraction of the facial muscles is, so to speak, the representation of the mental state, and it is obvious that under these circumstances any accidental movement of the shoulder muscles may give the face an expression quite out of keeping with the then mental state of the subject.

This drawback has led certain surgeons to prefer the hypoglossal in spite of the fact that its greater depth renders the operation much more difficult; moreover, the nerve is much smaller. A point in favour of the choice of the hypoglossal is that its cortical centre is much nearer that of the facial than that of the spinal; moreover, the medullary protuberances of the facial and hypoglossus are linked up by the posterior longitudinal tract. It follows that the re-education of the facial muscles, if this be possible, ought to take place much more readily with the hypoglossal than with the facial. Opinions differ as to the advantage attending this special method. Korte, for instance, considers the hemilingual atrophy and dysphagia which have been noted to be much more troublesome than the atrophy of the shoulder; but Bernhardt and Ballance both appear disposed to prefer the hypoglossus in future.

In estimating the value of surgical intervention in the treatment of facial paralysis from the twenty-two cases so far recorded, we must, in fairness, eliminate the "negative cases," that is to say, cases in which the operation is still too recent, and those in which, for special reasons, there was no justification for believing the subjects to be capable of improvement. In most of the other cases the lesion was of comparatively recent onset, rarely exceeding from six to ten weeks. Gluck and Alexander, however, had cases of five years' standing, and Hackenbruch one of nearly eight years' standing. It is possible, however, that the length of the interval between the division of the facial nerve and its anastomosis exerts some influence on the ultimate result, since the best effects were obtained in cases where the division and the anastomosis were performed at one sitting.

The previous duration of the lesion, on the contrary, does not seem to affect the greater or less rapidity of restoration of function, and in this respect the most marked differences have been observed. Side by side with a case reported by Cushing, in which the first symptoms of improvement were noted thirteen days after the operation, or with one by Kennedy, in which movements of the upper eyelid were seen seven days after, there are others, the more numerous, in which months elapsed before the slightest indication of returning muscular power was observed. Speaking generally, it may be stated that we must not expect any marked improvement under six months. The age of the patient does not appear to have much bearing in regard to the return of functional activity.

In the cases in which grafting of the facial nerve has been undertaken hitherto, the paralysis was invariably of peripheral origin. In the majority the nerve was accidentally divided in the course of an operation for aural caries; in others, as the result of wound by firearms, or in association with fracture of the skull. In only one instance (Taylor's case) was the operation performed for paralysis *d frigore*, and not once for paralysis of obstetrical origin. Judging from the published cases, therefore, the indications for surgical intervention are tolerably limited.

To form a trustworthy opinion of the value of this intervention we must have before us a clear conception of its possibilities, and of what may reasonably be expected of it. Treatment of a paralysed facial nerve means attempting to restore to the muscles of the face a motility in every respect comparable with that of the pre-paralytic period. The object in view is the *restitutio ad integrum*, and it is only when this is possible that we are entitled to discuss "the cure of facial paralysis." This being so, we may state forthwith that in cases which have resisted medical treatment, even surgical measures may prove ineffectual so far as concerns complete integral restoration of function. The anastomosis of nerves cannot possibly replace matters in the *status quo ante*. It can only be palliative; in fact, as Dr. Faure puts it, it can only aim at "correcting, in the state of repose, facial asymmetry and restoring tonicity to the paralysed muscles"—so that it is in reality a "cosmetic operation."

The disappearance of the facial asymmetry is therefore the principal—indeed, the only—benefit likely to accrue from the surgical treatment of facial paralysis. This result has been obtained, more or less, in a number of cases, though it is impossible beforehand to forecast with any degree of certainty to what extent the asymmetry will be corrected. It is only fair to add that, even taking things at their best, we are not justified in talking of "complete cure" of facial paralysis in these cases, as is so often done by enthusiastic partisans of surgical intervention. In the more successful cases—by no means in all—the facial asymmetry is modified with the muscles at rest. But it is only with the muscles at rest; for, after as before the operation, the play of the facial muscles is limited to one side of the face, the other half, corresponding to the anastomosis, remaining motionless. The only movements obtainable in this half of the face—after spino-facial anastomosis—are associated movements of the shoulder and face muscles. When the patient wishes to contract the facial

muscles he has to raise the shoulder, so that the facial muscles no longer contract spontaneously in response to emotions, and, therefore, no longer reflect the mental state. In the twenty-two observations only one patient developed movements of the labial commissure in laughing. Even in this instance various interpretations are possible. We know, for example, that according to some anatomists the fibres governing the labial commissures have their deep origin in the hypoglossal nucleus. On the other hand, the association of movements between the shoulder and the face so that the facial muscles contract whenever the shoulder is raised entails manifest drawbacks. The control which some patients seek to impose by grasping the motionless limb with the other hand is at best very imperfect.

We cannot disguise from ourselves that this is a very serious inconvenience. It remains to be seen how far it is possible to check this association of movements by systematic re-education. So far it has not been found practicable to suppress it if any tangible degree.

To sum up, grafting the facial nerve on to a neighbouring nerve may be the means of restoring a certain degree of tonus to the facial muscles, and thus in some measure remedy the asymmetry; but it cannot restore spontaneous movement to the facial muscles while, on the other hand, it often entails inconveniences not devoid of gravity. Moreover, the atrophy of the muscles previously under the control of the anastomosed nerve, which is inseparable from the procedure, is an unquestionable evil. Although in some cases the atrophy of the trapezius or semilingual atrophy does not determine grave constitutional embarrassment, in others the results have been disastrous.

These various considerations explain, perhaps, why this operation, seductively ingenious though it be, has so far attracted comparatively few partisans; indeed, we may well ask ourselves whether it is not likely to be abandoned as falling short of its object, the inconveniences determined by facial paralysis being, after all, less serious than those caused by the operation undertaken for the relief of the former. However this may be, should this procedure acquire a position in practical surgery, it would appear preferable, judging from the observations at our disposal, to select the hypoglossal-facial graft, thus avoiding the more serious troubles resulting from the spino-facial graft.

THE IMMEDIATE
REPAIR OF LACERATIONS
OF THE
PERINEUM:

WITH SPECIAL REFERENCE TO PLACING
THE SUTURES IN POSITION. (a)

By A. LAPHORN SMITH, B.A., M.D.,
M.R.C.S. Eng.,
Of Montreal, Canada;

Professor of Clinical Gynaecology in Bishop's University; Surgeon-in-Chief of the Samaritan Hospital for Women; Consulting Gynaecologist to the Women's Hospital, Montreal, Canada.

The importance of closing up small tears of the vagina and perineum has not so far been generally recognised by the profession. Year by year we have been getting to understand that deaths during the puerperium are due to a great

(a) Read before the Boston Meeting of the American Gynaecological Society, 1904.

many causes, and we see that just in proportion as we succeed in eliminating these causes the death-rate in childbirth is growing less. Infection still remains the greatest cause, and we have still much to do before the whole rank and file of the profession of midwifery realise the importance of making the fewest possible vaginal examinations, and of making even those few as nearly aseptic as possible. But since it is practically impossible to reach perfection in this direction, we must turn our attention to lessening the avenues by which germs may enter the system by immediately closing all tears so as to leave no raw surface in direct connection with the lymphatics. At one time it was thought that puerperal infection took place only through the cavity of the uterus and the tubes, or through the placental site; but since we have been opening the abdomen for the relief of puerperal septicæmia, we know that the infection frequently reaches the blood through the lymphatics, receiving lymph from the perineum, vagina and cervix. In nearly every case I have seen, the chain of lymphatics running up the side of the uterus was filled with pus. More than once I have seen the temperature come down promptly after washing out the uterus and vagina and packing the latter with sterile gauze, so as to stop absorption.

The question of the immediate closing of tears of the cervix has been assigned to other members taking part in this discussion. I heartily endorse all that has been said in favour of it, and I know of at least one maternity hospital where the procedure has been regularly adopted and with marked success. As regards tears of the vagina, they should be sewn up with a running, fine chromicised catgut suture while the patient is still under the anæsthetic. Owing to the ease with which the cervix can be drawn down or forward or backward with a four-pronged forceps, and owing to the great distensibility of the vulva, especially if it is torn, as it generally is when the vagina has been lacerated, there is no difficulty in seeing the tears in the vagina and closing them before closing the perineum. The field of operation can be kept clean by having copious constant irrigation going on, or the uterus can be packed with gauze temporarily to keep the usual trickling of blood from flowing over the vagina.

For the same reasons as the foregoing, namely, to prevent septic absorption, it is important to close even small tears of the perineum. During the last fifteen years I have made a regular practice of putting in a stitch or two in every case in which even half an inch of the fourchette had been torn. The result has been that my patients have been almost entirely free from the slight rise of temperature on the second or third day, which it has been customary to attribute to the milk, but which, I suspect, is due rather to a little septic absorption through these slight lacerations. I am certain that patients who have had these small lacerations of the perineum repaired have made better convalescences than those on whom it was not done. In the case of very considerable tears in the perineum, especially of those which extend through the sphincter into the bowel, the question of loss of function of the muscles of the perineum and of the pelvic fascia is still more important. Emmet has described the results of this accident so well that it is unnecessary to draw attention to it. Every member of this Society knows that the separation

of the levator ani and transversus perinei muscles disables a woman very considerably. Nature, it is true, tries to heal these tears, but she is only able to do it by granulations, which are converted into scar tissue, which in a place so full of nerves as this must cause reflex irritation when the inevitable contraction takes place. There are many other reasons why we should close all tears of the perineum, which are well known to the profession. I once operated on a physician's wife, a beautiful woman and a great social favourite, who was lacerated during her first confinement, and who was practically a prisoner in her room for the next twenty years, owing to the loss of control of the bowels. This in turn led to the wrecking of their domestic happiness, for the reflex irritation ruined her nervous system.

I admit that the immediate repair of the cervix, vagina and perineum is difficult in a poor house with poor light and poor assistants, and it would be better to send for assistance in the form of an expert in plastic work, who, with the help of a nurse and the family doctor, could quickly sew up all tears. But in cases in which such a man is not available, the family doctor himself, if provided with catgut and silkworm-gut ready sterilised, and a few Péan forceps, a few small curved needles, and a good needle holder, and above all, with a large curved perineum needle on a handle, can obtain very good results. The greatest difficulty consists in securing the divided ends of the levator ani muscles and pelvic fascia, which retract at once when torn; for it is of little use to sew up the perineum without taking in the muscles. This difficulty, however, can be overcome by a method which I have devised.

Just before the child's head comes down upon the perineum, the patient is anæsthetised and brought across the bed with the feet held by a twisted sheet or leg-holder. The perineum is sterilised with soap and brush and mercuric chloride, and then, with the large curved needle firmly held in the right hand, and with the thumb of the left hand in the anus and the left forefinger in the vagina, the needle is entered at the base of the lesser lip on the patient's left, and passed rapidly under the vagina and about two and a half inches above the fourchette, coming out at the corresponding point on the woman's right side. A silkworm-gut suture is threaded into it with the right hand and the needle is withdrawn, followed by the silkworm-gut, the two ends of which are caught with a hæmostat. A second one is passed in the same way an inch lower down, but taking in the muscles of the perineum. We can generally tell beforehand, by the rigidity of the perineum, whether the tear is going to be a bad one or not; in the former case we can put in a third stitch, which would take in the sphincter ani on each side of the middle line. Delivery can now go on naturally or artificially, but as soon as the placenta has been delivered the perineum is inspected under a good light and a stream of water, all clots being rubbed off with the finger; the stitches are tied from above downwards, when we shall find that there is absolutely accurate coaptation of the separated parts.

Speaking of the light in the confinement room, especially of the poor, we should always take steps before delivery to provide good light, for two reasons: (1) That we may see how dirty the place is; (2) to see what we are doing. As a rule, a

darkened room means a dirty and badly-ventilated room. In the daytime arrange the patient so that the perineum will be facing a bright window, and if the confinement is likely to take place at night, provide beforehand for a good light easily available for examining the perineum. When we hear physicians say that they never have seen a laceration of the perineum, they may be telling the truth, because they attended all their patients in a dark room.

The presence of the silkworm-gut stitches placed as stated, before the head comes through the perineum and hanging loosely attached by their ends to a forceps, does not interfere with the termination of the labour in any way; not even if forceps are required. If by keeping the pains under control and the head well towards the symphysis there has, happily, been no laceration, no harm is done by their having been introduced; you simply take off the forceps and draw them out. While if the perineum has been lacerated more or less, it is of great advantage to save time and trouble by having them already in, but still more so by having them exactly in the right place to bring the lacerated surfaces together; just as they were before the delivery. I have often heard Emmet say, "They might as well have sewed up her drawers as sew the skin of the perineum," referring, of course, to the failure to restore the muscles; and in many cases in which repair was immediately done I have had to do a secondary operation some years later for the restoration of the muscles.

In conclusion, I would strongly urge every accoucheur to have in his bag a sealed tube with a sterilised needle and catgut in alcohol, and another with six threads of silkworm-gut in alcohol, as well as a needle-holder, a bullet forceps and a perineum needle on a handle. As good light is a great desideratum, a laryngoscopic mirror or headlight would greatly facilitate rapid work.

The placing of the perineal sutures before the tear occurs is an instance in which "an ounce of prevention is worth a pound of cure."

CASE OF REPEATED ANENCEPHALIC BIRTH.

By DAVID RORIE, M.B., C.M.Ed.,
Cardenden, Fife.

In midwifery practice anencephaly is always sufficiently rare to attract notice, and the following case of repeated anencephalic birth is perhaps worthy of being chronicled.

The mother, Mrs. W. A., wife of a miner, is now *æt.* 40, and was married nine and a half years ago. During that period she has been eight times pregnant, and three of these pregnancies have resulted in the birth of an anencephalic foetus, two being males and one female. The detailed history is as follows:—

1. On November 18th, 1895, she was delivered of a full-term male child, pregnancy and labour running a normal course. This child is now alive and healthy.

2. On February 26th, 1897, she was delivered at full term of a male anencephalic foetus. During the pregnancy she complained of being unduly "swelled" in comparison with her previous experience, and in the last three months of severe lancinating pain on both sides of the abdomen. There was the hydramnios usual in such cases, and

labour was precipitate. The child was alive at birth, and survived some fifteen minutes. Ten days after its birth she rose for the first time, and, while sitting in a chair at the fire, was seized with a severe flooding. On reaching the house I found her blanched and practically pulseless. The uterus was relaxed, and it and the vagina full of clot. This was cleared away, and with hot intra-uterine douching, hypodermic injection of ergotin, and rectal injection of salt solution, she was brought round, and thereafter made an uninterrupted recovery.

3. On June 9th, 1898, she was again delivered at full term of an anencephalic foetus, a female. During the later months of pregnancy, she complained as in her previous confinement. Labour was again precipitate and associated with an undue quantity of liquor amnii. The foetus survived its birth for five minutes. I secured this foetus and sent it to Dr. J. W. Ballantyne, of Edinburgh, the well-known authority on teratology. In a letter he very kindly sent me at the time, he said:—"While such cases are very rare, it is a curious fact that it is not at all uncommon for a woman to give birth to two in succession, and even to three. I have noted two or three such cases." This statement is interesting in the view of later events. Later, he wrote again:—"The frozen section turned out very well, and showed, in addition to the anencephalic peculiarity, some torsion of the spine and absence of vertebral bodies."

4. On November 26th, 1900, she was delivered of a full-term male child, now alive and healthy. As the husband was very anxious that "something should be done" to secure the advent of a healthy child, the mother was, after the first month of her pregnancy, kept on a preparation of aletris farinosa. Pregnancy and labour were of a normal character.

5. On September 9th, 1901, she was delivered of an anencephalic male foetus at full term, the circumstances of pregnancy and labour being similar to 2 and 3. The pain of the later months of pregnancy, however, was much more severe, and on several occasions required the administration of opiates. I was not made aware of the pregnancy until she was in the seventh month of it, and no drug treatment was followed throughout it as in 4.

6. On February 6th, 1903, she was delivered of a full-term female child, now alive and healthy. Pregnancy and labour were natural, beyond the existence of a certain amount of hydramnios (not noticeable in 1 and 4), and throughout the pregnancy she took the preparation of aletris.

7. On August 3rd, 1904, she aborted at the fourth month. As far as I could make out, the foetus presented appearances natural to its stage of development.

At the date of writing the patient is again pregnant, is taking no drugs, and it will be a matter of interest to note the result.

Mrs. W. A. is a well-developed woman, of middle size, and more than average intelligence. The family circumstances are good. She is somewhat prematurely grey, but is not of a neurotic temperament. Until the birth of the third anencephalic foetus, she was not made aware of the foetal deformity, only knowing that they did not survive their birth. The husband is a healthy man of the same age as herself, and there is no history of

syphilis nor of other hereditary taint on either side. The three surviving children are in every way healthy and well developed for their age.

TWO CASES OF LUMBAR COLOTOMY :

WITH REMARKS ON THE ADVANTAGES OF
THE LUMBAR ROUTE.

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

CASE I.—Mr. J. A. B., æt. 63, was first seen on January 8th, 1904, with very advanced rectal cancer of about three years' duration. The whole circumference of the higher rectum was infiltrated, being hard, nodular and fixed. There was an enlarged gland in the left groin. The patient was a small, wiry-looking man. The urine was loaded with albumin, and there was much vesical irritation, in addition to the straining at stool. Morphia with cocaine was prescribed, and a glycerine with peppermint-water enema on alternate days.

Much relief was experienced until May, when it became evident that complete obstruction was impending. The tip of the finger could barely be passed into the diseased gut, the abdomen became greatly distended, and the intense suffering could no longer be alleviated. On May 27th, I performed left lumbar colotomy, with the valued assistance of my colleague, Mr. Ernest Miles. Considerable difficulty was experienced in hooking up the bowel, as the space between the last rib and the iliac crest barely exceeded one inch; but eventually the colon was sutured in Petit's triangle, and opened. For the next four days, frequent injections of glycerine were introduced for the removal of an enormous accumulation of hard scybala. The temperature was 99° throughout. The wound cicatrised in a fortnight. Within six weeks from the operation, the patient had gained nine pounds in weight. On May 27th, the fæces passed wholly from the loin, and the albumin had disappeared. In September, the patient cycled from London to Mitcham. He now goes about with a belt, and is able to enjoy his life, taking morphia with cocaine by the mouth, and also smoking opium occasionally. The disease has not made any visible progress since the colotomy. Nothing escapes *per anum* except a little flatus.

CASE II.—Ada L., æt. 22, married, two children, youngest æt. 9 months, was admitted into the Cancer Hospital on June 22nd, 1904. A haggard, emaciated woman, with every indication of poverty and neglect. Immediately beyond the sphincter ani, the finger passed within dense, hard tissue, whose upper limits could not be reached. The recto-vaginal septum was infiltrated as high as the posterior fornix. There were enlarged glands in both groins, and masses of the same above Poupart's ligament. On July 1st, it was found necessary to perform left lumbar colotomy in the usual manner, with great relief. The temperature subsequently was normal or subnormal. On September 20th, the note runs: "Comfortable; no pain; occasional slight anal evacuation, but nearly all passes by the side. Very weak and emaciated. Both legs œdematous." Death took place on October 4th. An autopsy showed infiltration of the rectum and sigmoid flexure for twelve inches above the sphincter. A large mass of cancerous deposit filled the pelvis, and implicated both broad ligaments. Hardly any lumen was to be felt at two inches from the anus. There were extensive metastases in both right and left supra-clavicular and cervical glands, in the axillary, bronchial and mediastinal glands. The ovaries, Fallopian tubes and bladder were infiltrated. The lower third of the uterus was enveloped by the growth.

Remarks.—The early age of the last patient, and the remarkable extensive deposits found, make the case noteworthy. I have not previously seen rectal cancer at so early an age. But apart from this consideration, the operation of lumbar colotomy seems now to have become obsolete; and any instance of its performance

is probably interesting on account of the rarity alone. The ease with which under ordinary circumstances the bowel can be reached in the inguinal region is presumably the main reason why the time-honoured procedure, once so well known in association with the names of Amussat, Callisen, and Hilton, are now altogether neglected.

Yet the inguinal route is by no means without its drawbacks, and the old-fashioned lumbar operation has much to recommend it. It seems to be forgotten that in the latter we open the bowel at least two inches higher up than in the former; that is to say, at the junction of the transverse with the descending colon, instead of at the sigmoid flexure. This does not much matter when the lower part of the rectum only is involved; but materially counts, both for immediate safety and for future advantage, when there is disease of the higher. More than once in an inguinal colotomy I have seen the meso-sigmoid in a state of extreme hypostatic congestion from proximity to the lesion. I have known seven or eight deaths from inguinal colotomy, and believe that if all cases were published, a high rate of mortality would become apparent. On the other hand, I have never heard of a death following the lumbar incision.

In both the cases above recorded, it would almost certainly have been impossible to bring the sigmoid flexure into an inguinal wound. In both, the first especially with marked albuminuria, it was essential to avoid unnecessary shock. In both, the natural progress of the growth was certain to complete the blockage, and to ensure full evacuation by the loin. In one, the extensive deposits, probably unprecedented, obviously precluded more than a few months' survival. In the first, the prompt disappearance of copious albumin from the urine after operation was concomitant with marked improvement in general health, which has continued to the present time.

It has been proved that a meso-colon exists on the left side in 36 per cent.; on the right in 26 per cent.; while in 52 per cent. this is wanting on both sides (Treves). Therefore, the chief advantage of old claimed for the lumbar route, that it avoided a peritoneal opening, is largely without foundation in actual fact. Yet the position of the wound ensures such close natural apposition of peritoneal edges as to have been in those days practically commensurate in safety to an extra-peritoneal operation. In both the preceding cases, the peritoneum was opened freely. The great point for future benefit is to secure the gut as high up as possible, and at as acute an angle as possible, thus ensuring a good spur. Difficulty in bringing up the colon is best met by a silk ligature passed temporarily through the entire lumen, merely for traction purposes.

Special Articles.

ASSOCIATION OF MEDICAL DIPLOMATES OF SCOTLAND.

A MUCH-NEEDED powerful organisation has recently been formed under this title, the first President being Dr. Claude St. Aubyn Farrer, with the following Vice-Presidents: Dr. Clouston, President of the Royal College of Physicians, Edinburgh; Sir Patrick Heron Watson, President of the Royal College of Surgeons of Edinburgh; Sir John Halliday Croom, Vice-President of the Royal College of Surgeons of Edinburgh; Dr. Henry E. Clarke, C.M.G., President of the Faculty of Physicians and Surgeons of Glasgow; Sir Alfred Cooper, F.R.C.S.Ed., Vice-President of the Royal College of Surgeons of England; Sir James Clarke, Bart., C.B., Sir Anderson Critchett, Sir John W. Reid, K.C.B., Sir John Sibbald, Sir John Tyler, C.I.E., Sir William Whittla, with Dr. William Bell as Hon. Treasurer, and Dr. David Walsh, Hon. Secretary.

Year by year the *Medical Register* contains the names of a large and steadily increasing number of medical men holding Scotch qualifications and practising in England, Ireland and Wales. Hitherto, these practitioners have lived in a sort of "No-man's Land," for they have been

for the most part out of touch with their own Colleges, with the local hospitals and societies, and, truth to say, with each other. To bring these scattered forces into line for the protection of common rights and interests, and for the removal of social and professional disabilities, is clearly a matter of common-sense prudence. Already the hearty response to the circulars issued by the Medical Diplomates of Scotland bears every promise of a full and brilliant future.

The Association has now assumed a definite shape. Rules have been drawn up, and a strong and energetic Council appointed. Broadly speaking, the objects of the Association may be defined as follows:—(1) To bring about a firm and lasting union between Scotch diplomates in town and country. (2) To advance the common interests of Scotch diplomates. (3) To provide a central meeting place for the transaction of all business that may come within the scope of the Association.

There are three directions in which the Association has decided to appeal to members:—

1. SOCIAL.—The Council hope to foster and encourage social intercourse among members by the agency of annual dinners, presidential and other addresses by distinguished men, *conversaciones*, smoking concerts, excursions, and the like. Some day, as the Association grows in strength, it may be possible to hold an occasional meeting outside London.

2. SCIENTIFIC.—The proposal to add another to the many existing scientific societies will naturally require abundant justification. To put the matter briefly, the Council think there is room for such a Society on the following lines, especially as there is reason to believe many Scotch diplomates have to some extent held aloof from local associations. They suggest the discussion not so much of abstruse and highly technical scientific questions as of common disease in relation to the everyday work of general practice. The presence of consultants, specialists, and general practitioners at these discussions would necessarily result in a crop of information of wide suggestive value. At the same time the Council feel it would be unwise to confine the work of the Association to abstract discussions. They propose that scientific meetings be held twice monthly during the Winter Session, and that alternate meetings be devoted to clinical cases, exhibition of drugs, instruments and other appliances, pathological specimens (including microscopes), radiograms, improved laboratory methods, in short, any matters likely to be useful to members in the practice of their profession.

3. MEDICO-POLITICAL.—A fair share of the formal meetings might be devoted with advantage to the many problems which fall outside the purely scientific aspect of professional life. In this way the Association would first of all form the natural mouthpiece of the Scotch diplomates as regards their rights and privileges in relation to those colleges from which their medical qualifications have been obtained. Hitherto, it has been the custom of the Scotch Colleges to act independently of the opinion of their diplomates, indeed, owing to the absence of any collective organisation, it would have been impossible to ascertain the views of their constituent *dicentiates*, members and fellows.

Medico-political matters with an everyday bearing on medical practice may be found in such subjects as—Hospital Abuse; Midwives Bill; Suppression of Quacks; Disabilities of Scotch Diplomates in Hospital Appointments (out of Scotland) and Otherwise; School Diseases; School Board Certificates and Medical Certificates generally; Police; Poor-law; Club and Dispensary Practice; Bills before Parliament; Medical Titles; and generally, anything concerned with progress in professional matters.

We understand that already nearly 200 members have given in their names, and the Council reminds all Scotch diplomates that everyone who joins in these earlier days will greatly strengthen the foundations of the A.M.D.S. (a)

(a) Forms of application and any desired information can be obtained of the Hon. Sec., Dr. David Walsh, 18a Hanover Street, London, W.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON.

MEETING HELD JANUARY 13TH, 1905.

The President, DR. FREDERICK TAYLOR, in the Chair.

MR. JONATHAN HUTCHINSON, jun., showed a case two years after intra-cranial resection of the second division of the fifth nerve. The case had been described in the Society's "Transactions, 1904," and adverse opinions were expressed as to the ultimate future of the case. The operation—that of nerve section between the Gasserian ganglion and the foramen rotundum—had been undertaken for epileptiform neuralgia attacks. Since its performance, the man had been entirely free from attacks and had suffered no inconvenience from the anæsthesia. He had several times travelled to and fro between South Africa and England, being exposed to much wet and cold—the most severe test possible.

ACUTE ASCENDING PARALYSES IN CASES OF CHRONIC CYSTITIS.

DR. T. J. WALKER had had in his practice three cases of long-standing chronic cystitis which had terminated fatally by a most rapid acute ascending paralysis. The first case was that of a baker who, at the age of fifteen, injured his urethra by falling astride a rail and who was under treatment for recurrent stricture and chronic cystitis from the age of twenty-five to forty years, but who was able to follow his work. An exacerbation of the chronic cystitis had occurred about a month previous to his final attack, for which he was under treatment, when in the course of a night the patient felt numbness in the feet and some loss of power in the legs. When seen the next morning there was paresis of the limbs up to the thighs and by that evening paralysis had extended upwards to the arms and thorax, the breathing became embarrassed and he died eighteen hours after the onset of the paralytic symptoms. There was no *post-mortem*. The second case was that of a farmer who was seen when *æt.* 52, with a stricture of the urinary meatus, for which he had sought relief only when retention and cystitis had made his life intolerable. For the following ten years the patient continued to have cystitis. At the age of sixty-two an exacerbation of the chronic cystitis occurred; this had been present for four days, but without retention, when in the early morning the patient experienced uncomfortable sensations and some muscular feebleness in the limbs. At midday there were distinct signs of paraplegia; on the following day there was considerable progress of the paralysis, and he died forty-eight hours after the first sign of its commencement. There was no *post-mortem*. The third case was that of a butcher, *æt.* 67, who had suffered for many years from chronic cystitis, and for the previous three months had required catheterisation on account of prostatic disease. He had been confined to his bed for some time, when, on getting out, he appeared feeble and unsteady. Twelve hours later there were distinct signs of paralysis of the arms, and the patient died eighteen hours after the first onset of the paralytic symptoms. There was no *post-mortem*. Dr. Walker referred to a case termed urinary paraplegia by Stanley, of a man admitted into St. Bartholomew's Hospital under Earle with gonorrhœa and phimosis, who died three weeks later, twelve hours after paraplegia had set in. Another case had occurred under Dr. Saunders in Birmingham. The author then discussed the pathology of Landry's paralysis and concluded that the connection is not a reflex nervous one, but an extension of microbes from the bladder to the spinal cord.

MR. CLEMENT LUCAS noted that in each of the cases described there had been cystitis of very long standing. Thus the connection between the cystitis and the paralysis was not a close one. He suggested that the cystitis was not causally related to the paralysis, but that this merely occurred in a person exhausted through long illness, which by chance happened to be cystitis.

Dr. FARQUHAR BUZZARD regarded the term acute ascending paralysis as being in this instance quite justifiable. He had pointed out on several occasions that Landry's paralysis was by no means synonymous with acute ascending paralysis, but was a term that should be restricted to the one of the three varieties of this condition, in which only very slight lesions in the cord could be detected after death. He would have expected to find in Dr. Walker's cases that marked changes had been present in the spinal cord and membranes, the conditions being an acute meningo-myelitis. This condition might be caused by a number of different organisms, such as the meningococcus, the gonococcus, those of the acute specific fevers, &c.

Mr. WALTER SPENCER drew attention to the resemblance of the condition to paralytic or "dumb" rabies that occurred in rabbits experimentally, and as a terminal phenomenon in canine rabies; there was reason to suppose that in man this form of hydrophobia might occur.

The PRESIDENT remarked on the extraordinary rapidity of the cases; he had never seen such a case. He deprecated the use of the term Landry's paralysis to describe such a condition.

Dr. WALKER, in reply, said that in a long practice he had never met with any such cases except in combination with chronic cystitis, and so could not but believe that a direct causal relation existed between the two. In the last two cases he had been able to accurately predict the course of the affection, a prediction unfortunately verified. He was not surprised that such cases had not been recorded, because the connection had never been noted. Indeed, even such a definitely recognised condition as urinary paraplegia, quite different from the one he had just described, was not alluded to in many books on urinary diseases.

CASE OF ACCIDENTAL ELECTROCUTION CAUSING EXTENSIVE GANGRENE OF ALL EXTREMITIES.

Mr. CLEMENT LUCAS described such a case in a boy, æt. 15, who had been admitted into Guy's Hospital, March 4th, 1904. The lad, an employé at the London Electric Supply Corporation station in the Blackfriars Road, was standing on a discharged barred shaped transformer so as to dust a ledge. He slipped and clutched at a cable, through which a current of 10,000 volts tension was passing. He was only in contact with this for thirty seconds. Respiration at once ceased, the limbs were burnt, swollen and stiff. Artificial respiration was immediately resorted to and the boy came round. On being seen soon after at Guy's, some shock was present, though this was not profound; the radial pulse could not be felt; he was conscious. The right hand was dead, white, strongly flexed and supinated; the arm showed solid œdema up to the shoulder; the forearm was crimson and peeling. The left hand suffered far less. Both feet were badly burned, there was anæsthesia and paralysis for four inches above the ankles. An everted wound in the axilla showed the point of exit; this was just behind a metal clasp of the braces. On the third day the right arm was amputated through the shoulder-joint, a short deltoid flap being used. Arterial thrombosis was found up to the origin of the superior profunda. He stood the operation well, and, as on the third day after the gangrene began to spread, both legs were amputated. Toxæmia set in, and death occurred on the ninth day after the accident. Other similar cases of recent occurrence were referred to and the condition discussed.

Mr. ASPINALL gave an account of the electrical engineer's aspect of the subject. He divided injuries from electricity into two groups—according as to whether the body came into the circuit or not—*i.e.*, as to whether the current flowed through the body or not. In the first group there were four varieties; high tension shock with good or bad contact, low tension shock with good or bad contact. He defined high tension as being of over 750 volts. In the second group, where there was no arc formed, he separated cases due to fright from those due to shock. He suggested that burning was inverse to the amount of shock. Mr. Lucas' case was an instance of severe burning due to an

enormous voltage and yet the lad came round. He had seen cases like Mr. Lucas' recover for a time after the passage of 20,000 volts through the body. In fatal cases it was rare to find burning. He remarked on the peculiar character of the cry that occurred in the shock cases, a characteristic sound, half sigh and half groan. Even after a fatal shock a man might speak, though this was rare. He advanced the suggestion that the vapour formed by the volatilisation of various metals or other substances might prove a factor in some rare cases, through aspiration of this into the lung.

Dr. WILFRED HARRIS agreed with Mr. Aspinall that the essential fact was not the actual voltage but the horse power behind it—*i.e.*, the current was the important thing. No harm ensued from a voltage of 100,000 or higher if this was of slight amperage, as in a static machine or X-ray apparatus. The amount of burning was inverse to the amount of current, and therefore of danger. Any resistance therefore increased the one and diminished the other. This was instanced by the irritation of a failing battery when the pad was dry, and its lessening after wetting the pad.

Mr. WALTER SPENCER read the following abstract of a communication on

ELECTRO-PATHOLOGICAL INJURIES FROM LIGHTNING STROKE AND ELECTRICAL CURRENTS OF HIGH TENSION, by Dr. S. Jellinek, Medical Officer in the Royal and Imperial Hospital of Wieden, Vienna.

Electrical currents are harmful according to the tension of the current and the resistance of the human body. A tension of 150 volts demands precautions, a tension of 200 volts and more may be dangerous; a tension of 500 volts may be fatal. But the harmful character of the tension is affected by the resistance. A man was killed near Prague by a current of 95 volts, when standing barefoot in a mixture of potash and sugar. On the other hand, an electrical employé in Vienna, though much damaged, was not killed by a current of 5,500 volts. Under resistance there is to be considered the resistance of entry and the resistance of exit. As regards the resistance of entry, there is the condition of the clothes dry or wet, or of the skin. The dry, horny palm of a workman may present a resistance of as much as 100,000 ohms; soft, moist skin, also lesions of the skin, have a very much diminished resistance, whilst the resistance of the mucous membrane of the mouth falls below 1,000 ohms. The resistance of exit depends upon the nature of the ground, also as it is usually the feet which connect with the ground, the covering of the feet. An electrical employé may come in contact with currents of high tension and do so with impunity, if the feet are covered with non-conducting material. In the case of the workman above mentioned standing barefoot in potash and sugar, the resistance of exit was very small indeed. The condition of the ground is most important; in private houses and in some mills the ground forms a good protection; mineral acid factories and coal mines, on the other hand, especially favour the occurrence of an accident. In making rules for the prevention of accidents, rooms and shops containing electrical installations should be distinguished according to the tension of the current and the nature of the ground into "the safe" and "the dangerous."

Mr. LUCAS replied.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF PATHOLOGY.

MEETING HELD FRIDAY, JANUARY 6TH, 1905.

The President, Dr. H. C. EARL, in the Chair.

ANÆMIC INFARCTION OF LIVER.

PROFESSOR O'SULLIVAN, for Dr. Roy Dobbin, showed specimens from a case of extensive anæmic infarction of the liver. The case was one of puerperal eclampsia, with jaundice. A large gall-stone was impacted in the upper end of the gall-bladder. The smaller branches of the hepatic artery showed an extensive degeneration of the walls, commencing in the muscle cells of the middle coat, and accompanied by

a similar change in the walls of groups of capillaries in the neighbourhood of the branches of the artery. The degenerated material took on Weigert's fibrin stain deeply, and gave none of the amyloid reactions. Hyaline thrombi were present in some of the arteries. The walls of the hepatic and portal veins were healthy. Some of the portal veins inside the infected areas were thrombosed.

ENDOTHELIOMA OF UTERUS.

The PRESIDENT and Mr. MAUNSELL showed an Endothelioma of the Uterus.

Professor O'SULLIVAN thought that in the present state of knowledge in regard to endotheliomata, unless one could establish the transition from the ordinary endothelium of the lymph space to the tumour endothelium, the diagnosis was not justified.

The PRESIDENT agreed with Professor O'Sullivan's remarks, and admitted that there were many parts of the tumour from which nobody could possibly establish a diagnosis.

MYOMA OF RECTUM.

The PRESIDENT showed a Large Myoma of the Rectum which was removed by Dr. Frank Golding, of Headford, from a woman during parturition. The tumour measured three and a half inches in its longest diameter by two and a quarter inches in its shortest. It presented some patches of calcification near its surface. It was attached to the wall of the rectum by a thin membrane.

Dr. TRAVERS SMITH asked was there any possibility of it being a uterine tumour which had found its way out *per rectum*?

The PRESIDENT said he did not think it was a uterine myoma, because he believed that if a patient had had a myoma like that eating into her bowel, she would have complained about it. Dr. Golding had also given a distinct history of its having a membranous attachment, which would not have been present if the tumour had eaten its way into the rectum.

POTT'S CARIES.

Mr. GUNN exhibited a case of Pott's Caries.

GASTRIC ULCER.

Mr. GUNN showed a Gastric Ulcer which he thought was of a tuberculous nature.

Professor O'SULLIVAN said he would like to ask the reason for supposing the ulcer to be tuberculous. The rarity of tuberculous conditions in the stomach made it worth while to examine it carefully if it was supposed to be tuberculous.

Mr. GUNN said the reason he thought it so was that there was old tuberculous disease of the abdomen and active tuberculous of the lungs, the patient probably swallowing a lot of the sputum. The ulcer was also tuberculous-looking, having thin, undermined edges.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

CLINICAL MEETING HELD FRIDAY, JANUARY 6TH.

C. M. TUKE, Esq., President, in the Chair.

Dr. Z. MENNELL showed a typical case of Acromegaly in a man, *æt.* 42. In 1883 he enlisted in the army, and his measurements were as follows: Weight, 10½ st.; height, 5 ft. 10½ ins.; chest, 37 ins.; and circumference of head, 21 ins. From 1887 until 1902, he had constantly to get larger boots, hats, gloves, and clothing, when latterly he could not get stock sizes large enough, and his measurements at present are: Weight, 19 st. 3 lbs.; height, 6 ft. 1 in.; chest, 47 ins.; and head, 25½ ins., which measurements have remained about the same during the past two years. His personal health is good, his only subjective symptom being occipital headache, with depression of spirits.

Dr. A. MORISON showed (1) a case of old-standing Mitral Stenosis with persistent choreic movements in a man, *æt.* 76. At the age of 14, he first had an attack of rheumatic fever, followed by clonic convulsive movements of the right arm; and when *æt.* 30, he had a second attack which was followed by a similar affection of the left arm; and (2) that of a man, *æt.* 51, with a

"renal heart," associated with granular contracted kidney.

Dr. J. B. BALL exhibited a man, *æt.* 52, with Tonsillar Disease of about six months' standing, commencing with considerable enlargement of the right tonsil and surrounding tissues, which eventually supplicated and discharged a quantity of necrosed *débris*, leaving a large, ragged cavity. Although there was no history of syphilis, it was considered to be gummatous in nature, and the case seemed to improve under anti-syphilitic treatment at first. A small portion of the tissue has lately been examined microscopically, showing the disease to be of a malignant type. Dr. Ball considered it to be a case of combined syphilitic and malignant disease.

Dr. A. GASTER suggested the patient be treated with large doses of mercury before accepting the case as one of pure epithelioma.

Mr. G. PERNET also suggested a course of mercury under strict observation, and apart from iodide of potassium.

Mr. R. W. LLOYD said that *local* mercurial treatment, combined with internal administration of anti-syphilitic remedies, might prove useful.

Mr. J. T. ARMSTRONG did not agree with the mercurial treatment, taking into consideration the microscopical report, and suggested antiseptic applications locally.

Dr. J. B. BALL briefly replied.

Mr. JOHN GARRETT brought before the notice of the Society a case of Granuloma Annulare, which occurred on the back of the right hand of a girl. It commenced as a papular rash about six months ago, the papules disappearing and leaving an indurated elevated margin around the centre, which regained its normal condition.

Dr. COLCOTT FOX said the disease was a very rare one, the etiology of which was unknown.

Mr. G. PERNET was of opinion that this case was not one of granuloma annulare, and showed microscopical sections of the latter disease.

Mr. D. J. ARMOUR showed a girl, *æt.* 26, upon whom he had operated for a Bilateral Ankylosis of the jaw. Both condyles were found to be fused with the zygoma, forming a solid mass of bone of ivory-like hardness. The zygoma just in front and behind the tuberosity and the neck of the jaw were cut through on each side, and the jaw was subsequently moved several times under *anæsthesia*. The patient can now separate her jaw easily and well, and is able to eat solid food, for the first time in her life.

Mr. D. J. ARMOUR also showed a specimen of a Polycystic Kidney which he removed from a woman, *æt.* 29, who made an uninterrupted recovery. Since the operation she has improved in health and is passing a normal amount of urine.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, JANUARY 15th, 1905.

FEVER AND SWEATS OF PHTHISIS.

It is well known that consumptive patients support a high temperature without any apparent inconvenience. Frequently patients can be found amusing themselves having 102° of fever. In such cases, says Professor Tyonnel, it is not necessary to interfere. But in other cases, on the contrary, the fever is very high, fatiguing the patient, and treatment is necessary.

Amongst the antipyretics at our disposal, antipyrine is the most innocent of all, and may be given with quinine:

Hydrochlorate of quinine, grs. v;
Antipyrine, grs. x.

Two to four daily.

If the antipyrine is not well borne by the stomach, it should be given with Vichy water.

Pyramidon lowers the temperature very quickly, but it frequently excites profuse sweating. Preference might be given to the acid camphorate of pyramidon in wafers of grs. x; three or four daily.

Phenacetin is also a good remedy, and may be associated with quinine and pyramidon :

Phenacetin, grs. v ;
Hydrochlorate of quinine, grs. iv ;
Acid camphorate of pyramidon, grs. vj.

For one wafer. Three of four in the twenty-four hours.

Sometimes simple rubbing with eau de Cologne or lavender spirit every evening acts favourably and is inoffensive.

Atropine is without doubt the most active agent, although not without danger. Some patients complain of dryness of the throat from its use, and say that they can no longer expectorate, while others present cerebral trouble.

Camphoric acid, white agaric, and ergot of rye often succeed and may be combined as follows :

Belladonna powder, gr. $\frac{1}{2}$;
White agaric powder, grs. ij ;
Ergot of rye, grs. iij ;
Camphoric acid, grs. x.

For one wafer. Two to three in the course of the evening.

TIC DOULOUREUX.

Tic douloureux of the face is well known where, during the attack, the muscles of the affected side are agitated by convulsive movements, which give to the physiognomy a grimacing attitude.

The malady (neuralgia) is very rebellious, resisting all kinds of antineurine agents, nor is it amenable to the electric current. Local injections of cocaine, stovain, morphine, phenic acid (2 per cent.) have been tried without much durable success. The resection of the painful branch or even Gasser's ganglion, or the superior cervical ganglion of the sympathetic nerve, alone has given satisfactory results. But this operation is very complicated, and many patients refuse to be so treated.

Sometimes the teeth have been incriminated ; but they have been extracted one by one without affording any relief. Cruet recommends incision of the gum down to the bone and the application of the thermocautery. This method, however, does not always succeed. In such a case, where the operation had given no relief, Dr. Sondaz tried the injection of proof spirit beneath the gum as practised by Prof. Pitres, of Bordeaux, for facial neuralgia. With an ordinary hypodermic syringe, M. Sondaz injected twenty drops of alcohol at 60 per cent. deeply under the mucous-membrane of the gum at the point where the pain seemed to start from. The injection produced a burning sensation, but was well supported by the patient. The following day the part was considerably inflamed, but rapidly diminished, while the pain was much relieved. A week subsequently another injection was made, but the consequent inflammation was much less marked, and the tic had completely disappeared.

The method seems to be very efficacious, and may be tried in all cases of neuralgia unrelieved by the ordinary treatment. The injections of alcohol produce a cessation of the pain and provoke slight and painless neuritis, which in its turn causes degeneration of the nerve cells.

A WONDERFUL PATENT MEDICINE.

The other day a long, lanky, and haggard man was brought up before the police court at Paris as being a vagabond. The magistrate asked him what was his profession. He replied that he sat as a model for a patent medicine against obesity ! Astonishment of the magistrate, who asked him to explain.

"I will tell you, your worship. I am engaged by a manufacturer of a drug, the virtues of which are supposed to rapidly diminish corpulency. I put on a whole garment of indiarubber and am blown out, just like the air tube of a bicycle. Then I am photographed, and my portrait is put in the window, with the mention, 'Before treatment.' About half the air is then let out and another picture is taken of me. This one is also placed in the window with 'One month of treatment,' and finally I am photographed as I am, which represents 'After two months of treatment' !"

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, January 15th, 1905.

In the *Deutsche med. Zeitung* is a reference to an article by V. Erdberg, St. Petersburg, on

BOSSI'S DILATATION OF THE CERVIX.

with a report of a case. The patient was a primipara, æt. 23. The fetus lay in the first position. The head could only be reached through the anterior vaginal arch with difficulty, as it lay high above the pelvic inlet. The patient had an attack of eclampsia. After hooking the anterior lip of the uterus, the dilator was introduced and carefully dilated. The membrane at once ruptured. During the dilatation, which lasted thirty and a half minutes, the tenseness and dilatibility of the os were carefully noted. The writer could confirm the observation of Bossi that the dilatation provoked uterine pains. The pains became stronger and the head sunk deeper. After complete dilatation no tear could be detected with the finger, only the cervix hung in the vagina as a loose sac, as it was usually felt *post-partum*. There was no hæmorrhage. The head in the pelvic inlet was pressed into the middle of the pelvis by Hofmeier's method—forceps. The child was born asphyxiated, but resuscitated. There was no hæmorrhage on extraction. The fits, however, did not cease after the birth of the child, and a few hours later the patient died.

In the *Arch. f. Dermatol. u. Syph.*, Hr. Ludwig Wallsch has an article on

NON-GONORRHOËAL URETHRITIS.

The writer has seen nine cases, five of them medical men. They were characteristic. First, by the long stage of incubation (five to sixteen days) ; second, by the mildness of both objective and subjective symptoms (slight itching or burning in the fossa navicularis, a plug of secretion that was washed away by the pressure of passing urine, or a few with many pus threads in generally clear urine) ; third, by the very chronic course ; four, by the entire absence of gonococci ; and five, by the failure of the usual modes of treatment. The prognosis was, therefore, bad. Some of his cases had been watched for a year, in two without any improvement taking place. His cases had never had gonorrhœa or syphilis ; they showed no signs of tuberculosis, and suffered neither from phosphaturia nor oxaluria. No micro-organisms that would be considered specific were ever found, nor could any be cultivated. Two of the patients married ; one of them was the father of two children, and the wife had remained healthy. Besides the cases described, Bockhart and others had showed that there were still other forms of non-gonorrhœal urethritis. The author had seen three other cases in which gonococci were never found, but large quantities of micro-organisms of the group of pseudo-diphtheritic bacilli were present. These were distinguished from the former cases by the short stage of incubation (three to four days) and the circumstance that the symptoms were mild, and recovery took place quickly. Finally non-gonorrhœal urethritis might be set up by chemical or mechanical irritation of the urethra, of which class the writer had seen two cases.

Dr. A. Fraenkel has an article in the *Arch. f. exper. Path.* on

THE CUMULATIVE ACTION OF THE DIGITALIS BODIES. The investigation forming the basis of the paper confirms in essential matters the practical observations of physicians. It was determined that there was nothing to show that animals became accustomed to the action of the bodies. The symptom of accumulation develops equally ; with increasing doses the symptoms of intoxication developed rapidly. The substances examined, digitalinum, serum, digitotoxin, and strophanthus behaved much in the same way. Individuality played but a small part. In each of the drugs a certain daily dose could be determined that could be continued for weeks, but the increase of the dose, even when only small, led in all cases to toxic cumulation. There was a difference in the tendency to cumulation

in the different bodies. The interval between doses of digitoxin must be considerably greater than in the case of digitalin if symptoms of intoxication are to be avoided. Digitoxin, therefore, is more cumulative. In single doses of digitoxin the difference between active and fatal doses was so small that the author did not succeed in slowing the pulse by subsequent doses, without causing death. With strophanthus and digitalin, on the other hand, there was no difficulty with regard to that.

THE TREATMENT OF BASEDOW'S DISEASE BY ANTITHYROIDEIN (MOEBIUS).

The *Deutsch. med. Zeitung* has a report of a case by Dr. J. W. M. Indermans. A young lady, æt. 19, had suffered for some months from Basedow's (Grave's) disease, and had been treated by Moebius' thyroid serum. She finally took as much as sixty drops three times a day, with the result that she got much worse, so that she was admitted into hospital. On admission, there was severe congestion of the heart, extreme exophthalmos, enlargement of the neck, attacks of delirium, hallucinations, coprolalia, lowered temperature, pulse 120 to 130, with systolic murmurs. The symptoms receded under morphia injections. After a time treatment was begun again, but this time with antithyroidein in small doses—five drops thrice daily, and later ten drops. After about 10 c.c.m. of the serum had been taken an improvement was noticeable, there was distinct diminution of the exophthalmos. Græfe's and Stellwag's sign had disappeared and also the periods; pulse 100. The thyroid had become slightly smaller and less fluctuating. The dose was then raised to fifteen drops thrice daily, and in six days the exophthalmos had quite disappeared. In five days more, after the patient had taken a total of 50 c.c.m. of serum, she no longer showed any outward trace of the disease.

SUICIDE OF THE KAISER'S DENTIST.

The profession this week has been somewhat shocked at the sudden and unexpected death of Hofrath Dr. Alonzo Sylvester, at his residence in the Tiergarten. Dr. Sylvester started practice here nearly thirty years ago, and won a unique position among European dentists. He was not only Dentist to the Imperial Court, but also enjoyed the German Emperor's close friendship for many years. He was well known for his large-hearted hospitality and generous liberality in all cases where charity was needed, and his house was one of the favourite resorts of literary and artistic society. He was an American by birth, and had reached the age of 57, when he put an end to his life for no apparent reason, by blowing out his brains with a revolver.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, JANUARY 15th, 1905.

THE NEW DRUG LECITHIN.

At the Gesellschaft, Exner demonstrated two rats on which he had experimented with lecithin and the Röntgen rays. He injected an aqueous solution of lecithin subcutaneously, and then applied the rays to decompose the salt. Six days after the injection deep ulcers gradually formed. The solution of lecithin was next boiled in order to sterilise it thoroughly, but the ulcers still repeated after injections and application of the rays. If the injections were performed without the subsequent application of the rays no change took place in the tissues. From this he concludes that the lecithin is decomposed by the Röntgen rays, and that the new product formed is an irritant. It was resolved to continue the examination of this new product on the lines of Zdarek.

ARTICULAR TUBERCULOSIS.

Handek, in his criticism of Moorhof's therapy of articular tuberculosis, said this method applied to children between the age of one year and ten, as it was most essential to locate the site of the disease before treatment could be commenced. When the morbid

changes can be located to the distal side of the joint, Mosetig's operation can be early performed, and conserves the joint in a fairly good condition. As stated before, Mosetig recommends early cutting down on tuberculous centres, and then applying the Röntgen rays to destroy any hidden germs in the neighbourhood. Massage in all these cases is of no avail; on the other hand, Mosetig's treatment is rational.

HYPERNEPHROMA.

Albrecht demonstrated from drawings and preparations a case of hypernephroma. The case was a man, æt. 60, who was admitted to the surgical clinic, but has since died. About the beginning of last year a small tumour began to develop on the outer half of the left clavicle. Röntgen rays revealed an abscess arising from caries of the clavicle. In July, the patient was received at the polyclinic suffering from a fluctuating immovable tumour about the size of a hen's egg, covered with a normal cuticle over the site mentioned. Nothing abnormal was found in the urine. The operation was performed and a great deal of blood lost in its removal. At this time it was presumed, from the subsequent examination of the structure, that the tumour over the clavicle had taken its origin from a metastatic condition, probably hypernephrotic. After this diagnosis the patient was transferred in October to the surgical clinic with a tumour about the size of a child's head on the anterior side of the left shoulder, having a reddish-yellow colour and bleeding profusely when cut. The urine was then again carefully examined and the abdomen palpated, but no abnormal condition could be discovered. Shortly after the patient died.

At the *post-mortem* a hypernephroma about the size of a large nut was present on the medial margin of the left kidney, another about the size of a bean on the lower portion of the right suprarenal body, as well as a few small adenomata, about the size of peas on the left suprarenal body, with metastatic tubercles in the left lung. The pathognomonic triad of hypernephroma, which are pain, palpable tumour, and hæmaturia, were imperfectly present in this case. Pain, it is true, was present a short time, but no tumour cells could be found in the urinary sediment. The osseous metastasis was the first and only trustworthy symptom recognisable in sixteen cases coming to the clinic, only three others having a similar appearance. Israel's presumption that palpation alone can diagnose these cases is very doubtful. The readiest way of confirming hypernephronic metastasis in the bone is by operating, and when assured of its presence the particular kidney should be discovered and a radical cure attempted by early operation, as the duration of the disease encourages this form of treatment. Kapsammer said that catheterisation of the ureters was of very little value owing to the insignificant changes present in the kidneys. The diagnosis, therefore, would depend more on operative examination of the kidneys as Küster had recommended, by exposing both and splitting if required. He recorded one where he could discover nothing by catheterisation, but by splitting found a large cavern in the upper pole.

Albrecht replied that malignant tumours had the advantage in this form of testing. Splitting the kidney could be done in tuberculous conditions, but he said there was little need for it in hypernephromata, as these tumours usually localised themselves on the surface of the organ, causing very little functional disturbance.

Hochenegg thought that very little information could be obtained from catheterising the ureters. On the other hand, feeble patients may be dangerously reduced by operative measures owing to the hæmorrhagic tendency. According to his opinion, the renal parenchyma was almost always found to be in a normal condition, and therefore no functional changes could be expected. Frisch admitted that the renal changes were slight, but with the assistance of the phloridzin method the slightest deviation could be detected. This was surely an easier and a safer form of diagnosis than laying both kidneys bare in order to diagnose such small tumours.

The Operating Theatres.

TOTTENHAM HOSPITAL.

ABDOMINAL HYSTERECTOMY FOR FIBROSIS.—Dr. A. GILES operated on a single woman, *æt.* 27, who presented the following history: For five or six years she had suffered from menorrhagia for which she had been curetted four times in the Tottenham Hospital. After each operation there was a slight improvement for perhaps one or two months, and then the hæmorrhage would return as badly as ever. The effect of the hæmorrhages was that the patient was constantly anæmic and weak. For a week before the period was due her strength would pick up a bit, and with the onset of the period she again lost strength. On the last occasion when curetting was done, Dr. Giles noticed that the uterus was rather undersized, its cavity appeared contracted, and hardly any endometrium was removed with the curette. The diagnosis of fibrosis of the uterus was made at the time, and it then seemed evident that if menorrhagia should return, nothing short of hysterectomy would be of any avail. The respite after this curetting was not of many months' duration, for hæmorrhage soon returned as badly as ever, the periods lasting as long as sixteen or seventeen days. Hysterectomy was then proposed to her, the nature and results of the operation being fully explained. She expressed herself as only too willing to undergo any operation that offered a hope of permanent cure. On opening the abdomen, a small uterus presented; it was removed by the supra-vaginal method, a considerable portion of the cervix being taken away. The right ovary was large and cystic, and was consequently removed with its tube; the left appendages were healthy, and were allowed to remain. Dr. Giles said that this class of case was one that had not yet received a great deal of attention, although some isolated cases had been reported. He had himself met with several instances of this condition. The principal characteristics of it were menorrhagia that could not be controlled by drugs or curetting; a uterus which was small, or, at any rate, very little enlarged; negative results on curetting, by which he meant that little or nothing could be scraped away. It might be supposed that the hæmorrhage came only from the body of the uterus, but he had a case some years ago in which he did a supra-vaginal amputation without troubling much about the cervix, and hæmorrhage returned so profusely that he had to remove the cervix later on; this was why he took care to remove a good deal of the cervix in the present case. He had chosen the abdominal route rather than the vaginal for several reasons: in the first place, the patient was single, and a vaginal hysterectomy would have been attended with considerable difficulties of manipulation; in the second place, he thought it was an advantage to leave the lower part of the cervix to complete the top of the vagina; and, lastly, the abdominal operation gave a cleaner convalescence, as there was almost always suppuration after the vaginal operation, until the ligatures had come away.

The patient made a very satisfactory recovery, in fact, she appeared to have been much less disturbed in her general condition by this operation than by the previous curettings.

ITALIAN HOSPITAL.

OPERATION FOR REMOVAL OF THE UTERUS, THE

APPENDIX, AND THE RIGHT OVARY.—Mr. LENTHAL CHEATLE operated on a woman, *æt.* 32, whose symptoms were: great and increasing pain at her menstrual periods and hæmorrhage. The pain was rendering her life unbearable; it was situated in the hypogastric and right iliac regions. The uterus was increased three-quarters of an inch in length, as demonstrated by the sound, and on bimanual examination was found to be enlarged. The patient had been to many medical men, but the treatment advised and undergone had given no benefit, therefore she was advised to have a laparotomy performed, and to allow Mr. Cheatle to do what he thought necessary after examination of the parts affected. On opening the abdomen just to the left of the middle line, the uterus was found to be slightly enlarged, no fibroids could be felt; the right ovary was cystic, being nearly the size of a Tangerine orange; the appendix was curled on itself, its tip being adherent to its centre, and the whole adherent to the back of the cæcum. The appendix was removed by the ordinary method of forming a collar of peritoneum. This was done with a special instrument devised by Mr. Cheatle (and made for him by Meyer and Meltzer), which appeared to admirably answer the purpose of separating the peritoneal coat from the subjacent muscular coat. The right ovary was next taken away, and the uterus and cervix removed; the other ovary, which appeared normal, was left behind. The abdominal wall was sewn up in three layers, no drainage being employed. Mr. Cheatle said that as all previous treatments, which had included curetting of the uterus and a varied and prolonged medical course, had proved futile, the patient only having intervals of a week between the attacks of pain and metrorrhagia, during which times only she could attend to her household arrangements, he considered it was about time for an attempt to be made to remedy by surgical intervention such a deplorable state of affairs. Although the pain might have been appendicular, he thought the removal of the uterus was justified with regard to the fact that the attacks of pain were always accompanied by metrorrhagia. With reference to the instrument he had used to separate the peritoneal coat from the muscular coat, it resembled a gouge, the end of which is bevelled, and has a chiselled edge. The instrument is capable of separating the peritoneal coat from the muscular and pushing it back.

The patient made an uninterrupted recovery as far as her wound was concerned. During the first three weeks after operation, her mental condition, however, was peculiar. She imagined she heard voices, and was in a very excitable condition. These transient mental phases have been before noticed by Mr. Cheatle among his cases of hysterectomy. The patient eventually completely recovered.

London School of Tropical Medicine.

OF the thirty-seven students who attended the above school for the Session October-December, 1904; the following eighteen passed the examination at the end of the course, the first four "with distinction":—Drs. J. H. Cook, D. Alexander (Colonial Service), T. G. D. Cooper (Colonial Service), D. H. Ainslie.

Passed in order of merit:—Drs. W. A. Densham, H. N. H. Joynt (Colonial Service), G. H. L. Fitzwilliams, P. Phillips (Colonial service), J. Gillies; Miss Kathleen Dawson; Drs. D. A. Ashton (Colonial Service), J. C. Carr, R. Dane (Colonial Service), J. W. Gromitt (Colonial Service), C. H. D. Ralph (Colonial Service), A. C. Lorena (Colonial Service), F. L. Norris (Colonial Service), W. F. L. A. Holcroft (Colonial Service).

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JANUARY 18, 1905.

THE HOSPITAL FUNDS, HOSPITAL POLICY AND SCOTCH QUALIFICATIONS.

THE need of some definite policy and declaration of principles in those otherwise most excellent institutions, the London Hospital Sunday and the King Edward's Funds, is abundantly proved by the way in which the present series of articles is being treated. Sir Henry Burdett has come forward, in the pages of the *Hospital*, as the champion and exponent of those Funds. His methods are neither particularly enlightening nor convincing. He confines himself to a triumphant exposure of non-essential errors of detail, while he leaves vital questions of principle unanswered. In proof of this proposition, in the last issue of the *Hospital*, that of January 14th, 1905, he states that the article in our last issue contained two misstatements: (1) That the Council of the Sunday Fund contains fifty clerical or lay members; (2) that the Fund has no representatives of the small hospitals upon either the Council or the Distribution Committees. Dealing with these points in turn, our first sentence should clearly have read "clerical and fifty lay members." But does the detection of this misprint justify Sir Henry Burdett in ignoring our contention that the making of grants was practically in the hands of the Distribution Committee, a small body of whom several leading members are avowedly antagonistic to the small hospitals? As to (2) our article said, "We fail to find on the Sunday Fund Council the name of a single representative of a small hospital." Sir Henry Burdett has discovered Mr. J. R. Cooper, chairman of the amalgamated Royal and Orthopædic Hospitals, and the two honorary secretaries of the Fund, Mr. Martin, who represents the St. Mark's Hospital for Fistula,

and Mr. Gilliat, the Royal Chest Hospital. This statement we accept, but can Sir Henry Burdett imagine that the presence of these three gentlemen upsets our contention that the small hospitals, speaking generally, are not adequately represented on the Councils either of the Sunday or of the King's Funds, for both were included in our criticism? Other vital questions in our article of the 11th are ignored by Sir Henry Burdett. We wished to learn if the whole facts of the sale of site and of amalgamation were in the possession of the committee of distribution of the Sunday Fund before they advised amalgamation, which, of course, connoted sale of site. No answer is given to this pertinent inquiry, or to the further question of how minutes are kept of such information, if, indeed, we may presume the committee had any laid before them; nor whether, as City men, past or present, Sir Henry Burdett and Sir Sydney Waterlow had perfect confidence in Mr. Harry Marks' financial policy with regard to the hospital. No answer, again, is given as to whether the Sunday and the King Edward's Funds had considered the objections of the minority who resisted Mr. Marks in his scheme to sell the site of the Orthopædic Hospital. These objections were urged by the *Lancet* and by ourselves, but have never been adequately met anywhere. It appears we were in error in saying the King's Fund pressed the sale of the site of the Royal Ophthalmic (Moorfields) Hospital, but it is none the less true that they are now paying enormous grants to help the bankruptcy arising from that sale of site. The Sunday Fund we believe, approved that sale, and are also helping to pay the piper. With that object-lesson before them we should have thought they would have afterwards exercised the greatest caution in advocating the sale of valuable sites possessed by hospitals, whether in pursuit of a policy of amalgamation or otherwise. It may well be asked why amalgamation was not pressed upon the Moorfields Eye Hospital as a condition of grants. There are far more eye hospitals in London than orthopædic. The fact is the more this question is discussed the more apparent does the absence of any definite settled principles of administration of the hospital funds become apparent. There is another point in connection with the amalgamation of the orthopædic hospitals to which we feel it desirable to call emphatic public attention. We understand, on good authority, that the National Orthopædic made it a condition of amalgamation that no surgeon without an English qualification should be permitted to join the fixed staff. That offensive condition was aimed at gentlemen with Scotch qualifications, and it was modified to the extent that one of the Royal Orthopædic surgeons having a Scotch qualification was permitted to join the amalgamated staff on the understanding that his term of office would be shortly terminated. The Sunday and King Edward's Funds approve the amalgamation. Do they know that in doing so they are playing into the hands of gentlemen

who are seeking to protect their professional position by the exercise of a grossly unfair advantage? The Funds are now urging the City Orthopædic Hospital to amalgamate. Do they know that the exclusion of non-English qualifications would at once dismiss the senior surgeon? The truth is that it is impossible for the Funds, without the fullest inquiry, to appreciate the consequences of enforcing this, that, or the other policy upon small hospitals. By all means let us have a central controlling power, but let that power be representative of all interests; let it be well informed, and let it act only on well-considered and clearly-defined principles. In no other way can the lasting confidence of the medical profession and of the public be secured. In the course of further articles we shall hope to provide further material worthy of the earnest consideration of the administration of the Funds. We are encouraged by the attitude of the Prince of Wales towards inquiry and economical hospital administration, and still more so by the well-known impartiality and sense of justice that have secured the admiration of Englishmen for his father, King Edward. There is no need for importing any heat into the discussion, and surely the Funds should be prepared to welcome criticism that is not conceived in any unfriendly spirit. Why, for instance, should not a small judicial committee be appointed to examine into the whole of the circumstances attending the sale of site and the amalgamation of the Royal Orthopædic Hospital? As things stand, the arguments of those who opposed that scheme have never been fairly heard, and certainly have never been satisfactorily answered. The Funds that can assume so great a responsibility as that of urging the sale of a freehold endowment site may reasonably take the smaller step of appointing a committee of inquiry.

SALINE INJECTIONS.

In no part of the field of physiology have recent researches been more rich in practical results than where the blood is concerned. Our knowledge of the functions of the leucocytes is of entirely modern date, and is intimately bound up with the physiology of defence against bacterial and toxic attacks. It is only a few years since plasma was regarded merely as the medium by which the red corpuscles were swept along with their load of oxygen for the tissues, by which food was carried to the parts and waste products were returned. Nowadays, however, it is known that these are but a few of several functions, and that the plasma is a fluid of bewildering complexity, whose intimate chemical constitution we are bound to discover. It was, however, somewhat prior to this discovery of the complexity of the plasma, and the consequent importance of maintaining its chemical equilibrium undisturbed, that the use of saline injections was discovered. In cases of shock, sudden hæmorrhage, collapse, and generally where the circulation needs support, as well as for the purpose of diluting poisons

already in the blood, every surgeon and physician has come to rely on the injection of saline fluid. He has not been taught, however, that it is of prime importance that this saline fluid should, as far as possible, resemble the plasma in composition. The solution commonly used is one of sodium chloride of 0·6 or 0·7 per cent., a percentage originally adopted, not because it was isotonic with human blood, but because physiologists found it the most advantageous in experiments on the frog. It may be stated that a solution of 0·9 per cent. would be far more suitable for clinical purposes. If the solution be either too weak or too strong it seriously injures the red cells of the blood, and doubtless also all other cells which it reaches. A variation of ·1 or ·2 per cent. from the physiological normal may cause damage, and with a ·5 per cent. solution of sodium chloride the corpuscles are actually destroyed. Not only, however, is it necessary that the sodium chloride solution shall be of accurate composition, but it is of advantage that certain other substances should be present. Thus, Dr. Ringer has shown the advisability of adding a small quantity of calcium to the salt solution, and more recently he and others have shown that potassium should also be present. In addition to preventing direct injurious effects on the cells of the blood, it has been shown that the presence of calcium prevents the occurrence of glycosuria, a phenomenon which not uncommonly follows a saline injection. It behoves surgeons and physicians, then, to exert the greatest care that the saline injections they employ are, in the strictest sense, "physiological"; a slight variation may mean the difference between the health and disease of "the blood, which is the life."

RURAL HOUSING.

THE unusual, we might almost say dramatic, incident of one of His Majesty's judges of the High Court being summoned to appear before a bench of country magistrates sitting in petty sessions would at any time arrest the attention of the most phlegmatic citizen. And the point at issue between Sir William Grantham and his prosecutors, the Chailey Rural District Council, is well worth all the attention that will be directed to it. It would be difficult to exaggerate the importance of the question if looked at in its ultimate bearings, although the actual dispute would appear from the line taken by Sir William Grantham's counsel to have been considerably over-laid with personalities. This question in effect is: Is it possible in England to construct a cheap, comfortable, sanitary cottage for the agricultural labourer? On the answer to that question depends to a great extent the retention of the labouring population on the soil, and such retention means the preservation of the springs whence are derived the best types of British physique and vigour. One hears nowadays on all sides complaints as to the overcrowding of towns, and the consequent mental and physical degeneration of the population, and although it has been

shown that these complaints, like many others, are exaggerated, still there is no denying the fact that the health of urban is not, and cannot be, as good as that of rural populations, and after several generations the adverse influences of town-life are bound to show themselves in the frame and constitution of the people. There is also widespread and natural alarm at the increase of insanity of late years. In London, since the County Council took over the administration of the asylums in 1889, though the general population has only increased by $12\frac{1}{2}$ per cent., the insane poor, who have to be provided for, number half as many again as they did fifteen years ago, and each year their ranks are swelled in proportion. It may not be fair to attribute this increase entirely to the conditions of town-life, but there can be no doubt that those conditions are responsible to a greater or less extent. Slums have never yet produced the finest type of man, and if the country districts are to be depleted of their inhabitants, the outlook for the race in the long run will be a gloomy one. Now, among economists, fiscal and otherwise, and hygienists who have studied the question, one of the chief problems in the retention of the agriculturist in his native haunts is the possibility of giving him a home at a rental which he is able to pay, and which at the same time will remunerate the landowner or farmer who has sunk his capital in its erection. A cottage of sorts can, of course, be built, but owing to the exertions of hygienists the sanitary requirements of cottages have been fixed at a level that makes a cheap cottage which accords with the standards laid down by the Building Acts, and the by-laws made under them, very difficult to provide. Far be it from us to minimise the importance of such sanitary requirements; an unhealthy cottage is only a shade better than no cottage at all, and a robust race would deteriorate if forced to live in dark, damp houses furnished with improper conveniences, and supplied with contaminated water. On the other hand landowners cannot be expected to build cottages which do not pay them as an investment, and agricultural labourers cannot pay rents that swallow up half their scanty incomes. The problem of the cheap cottage is, we repeat, one of national moment, and we note with satisfaction that the proprietors of the *County Gentleman* are making a public-spirited endeavour to solve it by giving substantial prizes for the best cheap cottage erected at the exhibition they propose to hold. Intrinsically difficult as the question is, it is complicated still more by the by-laws of the local authorities, and by the spirit in which these by-laws are administered, at least in some parts of the country. Urban authorities animated by no other desire than that of promoting the public good find themselves constantly thwarted and hampered by the conditions laid down by the Local Government Board with regard to the financial arrangements for the carrying out of their housing schemes, and private gentlemen are liable to similar annoyance from the

authorities they come in contact with. Sir William Grantham, apart from his high office, is well known as a squire of the best type, who is deeply concerned for the welfare of the workers on his estate and who wishes to act up to the full measure of his responsibilities. One of the economies he tried to introduce into cottage-building was that of preparing his own plans—a task he was to some extent qualified by his previous legal experience—but the resulting plans did not commend themselves to the critical judgment of the local surveyor and the Rural Council of Chailey. Consequently, instead of trying to aid him in his well-intentioned, if somewhat amateur schemes, after a good deal of to-and-fro correspondence, a summons was issued for Sir William to attend before the magistrates. As the bench did not arrive at a clear decision and further steps are hinted at, we refrain from commenting on the technicalities of the case, but we cannot help remarking that all possible attempts to make rural housing cheap as well as sanitary deserve and must command the sympathetic interest of all who desire to maintain and improve the health and physique of the nation.

Notes on Current Topics.

Coroner and Infantile Mortality.

THE cheapness with which infantile life is held in some countries is rightly regarded with horror by Englishmen. Nevertheless, it cannot be denied that there still exists in many quarters a lamentable indifference on the part of the parents to the safety of their offspring. Overlaying is an evil which, though happily becoming less, is nevertheless rife, as may be seen by the fact that in 1902 1,600 inquests were held in England and Wales upon babies suffocated in bed. In a recent account of an inquest held upon the body of an infant which had thus succumbed, Dr. F. J. Waldo, Coroner for the City of London, is reported to have said that he did not believe that intemperance of the parents was the cause of these deaths save in a few instances. This may or may not be the case, but the coroner's statement has evoked considerable criticism, and Canon Horsley is one of the first in the field to challenge his remarks. We presume the coroner's original reference was based upon inquiries made by his officer, the only available investigator in such cases. The reverend gentleman takes exception to the word "generally" employed by the coroner, who stated that he "generally" made careful inquiries into the circumstances attending the death of overlain infants. The evidence of the Coroner for Newcastle-on-Tyne is quoted against the statements of Dr. Waldo, to the effect that deaths from suffocation invariably occur between Saturday night and Sunday morning, just at the time when the parents are apt to go to bed under the influence of drink, the workmen having received their wages at mid-day on the Saturday. During the festivities of Christmas a larger proportion of deaths is said to occur from this cause.

and Canon Horsley finds it difficult not to believe that the two events stand in the nature of cause and effect. Intemperance is certainly not the only cause of this form of infantile mortality, though it has to be reckoned with. The obvious remedy for this state of affairs is the provision in every home of separate cots for babes, a provision that, by the way, is compulsory in Germany.

"Following the Midwife."

THE most unenviable notoriety that a practitioner can get is that of "following a midwife"—a term which in poor districts conveys a low estimate of a doctor's status. Moreover, when a midwife is "followed" it is done generally to relieve her of the onus of a bad case which has often been left too long untreated; and as the midwife was originally engaged from motives of economy, the prospect of the doctor getting a fee for his trouble is very remote. Some practitioners make it a rule not to go to such cases at all, or only when their fee is tendered, and it is easy only to those who know little of the conditions to utter any word of criticism on such an attitude. At an inquest on a newly-born child at Wood Green last week the midwife is reported to have said that a doctor was called in, but that, seeing no signs of a fee, he refused to have anything to do with the case. The Coroner, in his remarks, said that if the woman had been properly attended to the child's life might have been saved, and that happily ninety-nine doctors out of a hundred would give their services willingly whether they saw any signs of a fee or not. The lesson to be drawn from the circumstances is the manifest one that it is dangerous to allow unqualified persons to conduct confinements without skilled supervision; but this does not seem to have struck the listeners, nor that the doctor's attitude is about the only one by which a man can prevent himself from being landed in an invidious position in which it is not right or fair that he should be placed.

Vaccination and Red Light.

THE controversy started by Finsen's announcement of the abortive influence of red light on the development of the small-pox papule has yet to be settled finally. Ricketts and Byers, in London, have pronounced definitely against any tangible effect being produced, whilst Nash and others are inclined to believe that there is some virtue in the method. It would be interesting if some medical officers with the requisite facilities would carry out a series of experiments on the effect of red light on vaccinia. If the patients could be kept in a ward lighted entirely by red glass from the time of vaccination to the time of maturation of the resulting lesion, important information might be forthcoming as to the probable effect of the treatment in modified small-pox when early placed in similar surroundings. In the meantime we notice that Knöpfelmacher and Schein^(a) have been making

trials of a similar procedure in Austria. Eighteen consecutive children were vaccinated by them on one arm in a red-lighted chamber, the wound being afterwards covered with a red bandage, whilst the other arm was vaccinated and exposed to daylight. In thirteen other children vaccinations of both arms were performed in daylight, one arm being subsequently bandaged with red material the other with calico. In the former series they thought the arms vaccinated in red light and covered with red bandages showed a slight delay in the development of the pustules, whilst in the latter series no difference at all was perceptible. Although it does not necessarily follow that because red light is of no use in vaccinia, it is therefore of no use in small-pox, still, considering the strong parallelism between the two diseases, the evidence thus obtained is significant.

Medical Men and Lay Papers.

WE regret to see in the *Nineteenth Century* for January an article entitled "The Cause and Prevention of Appendicitis from a Physician's Point of View," under the signature of Joseph Kidd, M.D. It always has been, and still is, regarded as bad form for medical men to write on purely professional subjects in popular journals. The reasons for this are sufficiently obvious. An editor, however able, who is not possessed of technical knowledge cannot judge of the value of a medical article—and consequently fantastic rubbish arranged in plausible garb is quite as likely to be inserted as good matter, and in our experience the former is generally the case. Then, too, lay readers are apt to form the opinion that Smith, M.D., or Jones, F.R.C.S., who finds his way into print in the columns of their favourite magazine would not have been allowed the honour unless he had been possessed of special qualifications for the task. Here, again, our experience is totally opposed to the idea of the best man being asked to write. Moreover, articles of the class we are dealing with are almost invariably written with an air of authority that conveys the impression that the writer's statements are the authoritative expression of accepted medical opinion, whereas when they rise above the level of trivial banalities their statements are generally pretty wide of the truth. There is no lack of medical journals, weekly and monthly, to which contributions worthy of professional attention can be sent, and in whose columns criticism from qualified persons can strengthen or diminish a writer's theories, as the case may be. It is, then, in the highest degree undesirable that communications like Dr. Kidd's should be sent to lay magazines, especially when the writer's name is appended. The particular article in question is hardly worthy of notice either from the point of view of subject matter or style, yet it has received wide quotation in the sensation-loving press organs. We are far from deprecating the proper dissemination of hygienic knowledge on public questions—such as the effects of bad housing, impure water, and improper

(a) *Wien, klin. Wochen.*, 1904, Nr. 40, p. 1069.

education on the health of the nation—in standard magazines; indeed, we should like to see medical men possessed of the proper qualifications to speak with authority using their opportunities more freely in this direction. But all such articles must be obviously dictated by a transparent desire for the public welfare, and entirely free from any suspicion of faddism or self-seeking.

Concealment of Trachoma.

AN ingenious and interesting device adopted by immigrants to America to evade the inspection officers of the Public Health Service has lately been brought to light. The diseased alien does not receive the same open-hearted welcome in the States that he does on arriving at Tilbury, and strict surveillance is exercised on the steerage passengers of the trans-Atlantic liners to prevent any that are suffering from communicable diseases being allowed to land. One of the diseases which are frequent causes of rejection is trachoma, and the rebuffed immigrants have evidently been laying their heads together to baffle their foe, the port doctor. The story of their discomfiture is told in the "Reports of the Public Health and Marine Hospital Service." The health officers had for some time been noticing that certain passengers whose appearance suggested trachoma presented, on examination, no sign of the disease, but instead a blanched condition of the conjunctival mucous membrane. After they had noticed this several times they set some of the cases aside for re-examination, and when the lids were everted again after an interval of an hour or two they discovered, to their surprise, that the previously pale conjunctiva presented unmistakable signs of early trachoma. The explanation that lay at the bottom of this unusual phenomenon was revealed by closely watching a party of immigrants, who were waiting for examination. A number of these were seen to slink behind a convenient enclosure, and there were observed to be putting drops of some fluid into each other's eyes. This fluid was found afterwards to be adrenalin chloride solution, which has the power apparently of concealing the granular appearance of the lids in early trachoma by bringing about general blanching of the mucous membrane—a state of things that lasts for half an hour or so after the instillation. How these passengers came by this curious piece of pharmacological information does not appear, but the trick has evidently been in vogue for some time, and we believe it is a novel item in the science of malingering.

A Strange Medical Career.

FROM Mr. W. H. Wilkins' latest work, "A Queen of Tears," the current number of the *Practitioner* makes several interesting extracts illustrative of the career of Struensee, an obscure physician of Altona, who rose to be virtual sovereign of Denmark. Born in 1737, the son of a Lutheran minister, and educated in medicine at Halle, he was medical officer of Altona in 1768, and thinking of seeking a remedy in the East

Indies for the fortunes broken by his extravagant and sensual mode of life, he was by chance recommended for the post of travelling physician to King Christian VII. of Denmark. He was so successful in ingratiating himself at Court that a year later, when the girl Queen, who was on bad terms with her husband, fell ill, she became his patient. This lady, then seventeen years of age, was sister of George III. of England. Struensee now devoted all his energies to obtaining power over her, and by his help she soon regained her influence over the half imbecile King, and, being popular with the people, her power knew no check. In fact, Struensee, Court physician and lover of the Queen, was for the time supreme in Denmark. He attempted startling reforms—abolition of serfdom, reform of the marriage laws, lighting of Copenhagen, liberty of the press—in fact, he tried to carry into effect the political ideals of the French constitution-spinners. This absolute power went on for two years, when a sudden movement of the old Court Party, led by the Queen Dowager, and backed by the fickle opinion of the people, threw poor Queen Matilda into prison and hurried the adventurer to his death. But, speedy as was his punishment, it was not fast enough to prevent his rounding on his mistress, and, in a blackguardly confession, exposing her pitiful story. She, poor victim of his insatiable ambition, died three years later, divorced and disgraced, at the age of twenty-three. Of his short-lived greatness only one memorial remains—the Foundling Hospital at Copenhagen.

Misleading Statistics.

THERE IS, perhaps, no subject in which the untrained mind is more apt to go astray than statistics. One constantly sees a quite honest man, by a perfectly unintentional misuse of figures, arrive at conclusions which will not bear for a moment the examination of a skilled statistician. One of the latter class, indeed, Professor Karl Pearson, has recently pointed out the crying need there is for a more exact treatment of statistics in medical science. And though, perhaps, as an expert Professor Pearson is inclined to see too large the ignorance of non-experts, yet, in the demand for more exactness and greater care in the use of figures, we cordially agree with him. A good example of what we mean by misleading statistics is the set of figures put before the General Medical Council each year showing the numbers of successful and unsuccessful candidates at the different Service examinations, classified according to the respective qualifications they hold. Now, if this return has any use whatever it is as throwing what a contemporary calls "a sidelight upon the educational methods and curricula in force in different parts of the United Kingdom." That is to say, it is to be regarded as furnishing some sort of criterion of the education furnished by different licensing bodies, those which supply the highest percentage of successful candidates being considered as furnishing the best education. Many criticisms might be urged against such a

view, which, nevertheless, is probably in the minds of most people when they read the returns, but we mention only one obvious fallacy which vitiates the whole conclusion. This is that there are no data to show whether the candidates from each body are in any way representative of that body. It may be that only the mediocre men from one school care to present themselves, the better men choosing other careers. From another school the good men may present themselves in large number, no other career being open to them. In such a case the percentages of success are no measure of anything except of the candidates themselves, and we know that in regard to some of the schools concerned this very condition holds.

Electricity and Rheumatism.

THERE has been something of a boom during the last year or two in that form of entertainment which performs the double function of gratifying pleasure-seeking audiences and of demonstrating the healing gifts of the entertainer. The individuals who make a living by this means are queer combinations of the showman, the conjuror and the quack; but they have always sufficient self-assurance to exercise their arts to the greatest advantage, and generally manage to hypnotise their audiences as effectively as they electrify their patients. One of the most successful of the species is "Professor" Richard, M.E., who is now favouring Hastings with exhibitions of his skill. From the reports that reach us he seems to have been highly successful, both in drawing audiences and "curing" patients. Paralysis rapidly improves under a few minutes' application of electricity, and rheumatism permanently disappears when the affected part is manipulated by the Professor's hands. Sufferers from deafness, bad eyesight, neuralgia, and "almost" any other complaint are invited to subject themselves to the influence of the vital fluid with which the Professor is charged; and though no patients suffering from these maladies seem yet to have come up for treatment, we have no doubt that they will be reported as cured or permanently relieved when they do. The local press contains graphic accounts of these magical exhibitions and the humorous interludes with which the tedium of watching sufferers being cured is relieved, whilst Richard is extolled as a benefactor to the human race. It speaks little for the reflective faculties of people who think thus that they fail to take into account the itinerant habits of such professors, for if the treatment was really of any avail surely the wonderful curers would rapidly amass large fortunes by taking central offices and carrying on a permanent business: As it is, having obtained a certain notoriety by judicious use of the puff in its various aspects, and secured a certain reward for their efforts, they move on before a reaction in popular feeling has had time to set in. There is a serious side to demonstrations of this sort which hardly calls for comment to medical readers. If the Professor or any of his kidney should happen to inflict any injury when using

powerful electrical instruments on those persons who are silly enough to submit to their ministrations, there might be awkward legal complications. But in such a case one could trust the Professor to look after himself.

The Ante-Partum Insertion of Perineal Sutures.

WE publish in the present number an interesting communication by Dr. Laphorn Smith, a well-known Canadian gynaecologist, in which he advocates the insertion of perineal sutures before the birth of the foetus, in anticipation of the occurrence of laceration. The practice which he advocates is a novel one, and, in so far as it draws attention to the usual occurrence of perineal lacerations in almost every primipara, and to the necessity of immediately suturing them, his communication possesses a high value. Further, his method is harmless, and in many cases we can quite believe that the sutures, when tied, will cause accurate coaptation of the parts. It is not, however, an ideal procedure, nor one that is likely to attain wide acceptance. We are entirely at one with Dr. Smith in his agreement with Emmet that one "might as well sew up her drawers as sew the skin of the perineum," and we therefore prefer to see and know the entire extent of the laceration before commencing to suture it. Superficial lacerations of the perineum involving only the anterior half of the perineal body are easy to suture under any circumstances. They can be sutured in the dark by the sense of touch alone, if the medical attendant is so foolish as to try to do so, and, even if the sutures are not passed with absolute accuracy, union will result provided that infection of the wound does not occur. The lacerations that extend up the vagina, on the other hand, are at once most difficult to suture correctly and most serious in their after-consequences if union is not obtained, and, in their case, we do believe that accurate coaptation will be obtained by anticipatory suturing. Rather, we should prefer to advise the medical man to postpone the suture of these cases, when they occur at night in a badly lighted room, until the following day. The posterior vaginal wall can be then exposed, the vaginal rent sutured from the vagina, and the perineal body sutured in the usual manner by sutures passed from the skin surface.

Ankylostomiasis in England.

IN view of the infection of some of the Cornish tin-miners by the ankylostoma, it is of importance to take every possible precaution to prevent the spread of this parasite. Should it gain a wider distribution, and, more particularly, should it obtain a permanent footing in the coal-mines of the country, a serious danger to the mining industry of England will result. An object-lesson of what may be expected in such a case is to be got by observation of the actual condition of affairs in the mining districts of Westphalia and Hungary. Within the last two years it is stated that the mine-owners of Westphalia have spent £100,000

in the struggle against ankylostomiasis. If this sum is spent in order to get rid of the disease, an incomparably greater amount would be required to represent the economic loss due to it. A few years ago in some of the Hungarian mines no less than 90 per cent. of the workers suffered from ankylostomiasis, but nowadays, thanks to rigorous hygienic measures, the percentage has run down to thirty. Fortunately, the necessary precautions are not difficult to follow. In England no foreign miners or miners from infected districts should be allowed to work until they have undergone a thorough medical inspection, with expert examination of the blood and fæces. Defæcation in the pits must, moreover, be absolutely forbidden, unless where proper sanitary provision has been made. If these simple rules are loyally followed out, there is little danger of any serious ankylostomal infection.

Medical Phraseology.

THE cheap sneers at medical phraseology, indulged in by the recognised wit of the metropolitan Bench of magistrates—Mr. Plowden—are, to say the least, uncalled for and undignified. Mr. Plowden, as a member of the Bar, must be fully aware that most legal terms are no more understandable to lay persons than are those which belong to medicine. In a recent case before him he angled for applause in his court by attempting to throw ridicule upon the term "epistaxis" used by a practitioner. Instead of sneering at a medical term which he did not understand, we venture to suggest, having regard to the phraseology of his own profession, that it would have been more dignified on his part to have asked for an explanation, more especially as he must know that there are many terms used in medicine, which, in the vernacular would sound both rude and objectionable.

Diagnosis at Infectious Hospitals.

IN the reports issued by infectious hospitals a note is often made of errors of diagnosis made by general practitioners with regard to supposed diphtheria, small-pox, scarlet fever and so on. The converse case, that of mistakes made by the hospital medical staff, is naturally enough not officially mentioned. That such cases must now and then occur is obvious enough if we consider the difficulty, or even impossibility, of diagnosis in early and anomalous stages of many general infections. Speaking broadly, it is less excusable to make such error in the later or hospital stages than in the early and often more or less masked conditions that come under notice in general practice. Moreover, there is no appeal against the decision of the medical superintendent at the fever hospital. The only time that he is likely to be called upon to justify his opinion is when an inquest takes place. The superintendent of a London suburban small-pox hospital last week had to admit his error in refusing admission to a patient whom he took to be suffering from some form of skin disease

and not from small-pox. The man died soon after from hæmorrhagic small-pox. Some errors, humanly speaking, must occur under any system. It is rarely, however, that a careful examination by a skilled observer could fail to detect the presence of small-pox. In any case the sick man might have been kept in a probation ward. Here we find the opinion of the general practitioner of more value than that of the expert. The moral is obvious.

Revivalism and Mental Disease.

THE report that ten patients have been admitted into the Denbighshire County Asylum as a result of the recent revival in Wales is not, perhaps, altogether surprising. The causes which upset the mental equilibrium of neurotic and unstable individuals are sometimes so trivial that it is hardly to be wondered at that this new excitement has turned the brains of the unduly impressionable. Religious excitement is regarded by the general public as one of the most frequent causes of insanity, and, indeed, many text-books of mental diseases devote no small space to the discussion of the so-called "religious mania." As a matter of fact, most asylum physicians have found that religious disturbances are often more a symptom than a cause of insanity. Ideas of extreme unworthiness, of being irreparably lost, or of having committed "the unpardonable sin" are sometimes dominant features of the mental state of melancholics of a certain type. As Dr. G. H. Savage has aptly remarked, religion more often colours than produces insanity. It is youth and middle age that are chiefly affected by outbreaks of religious excitement. The appeal to the higher emotions is often irresistible to such, and the more unstable ones are not unlikely to become mentally unhinged. It must be admitted, however, that the proportion of those who drift into asylums as an outcome of an extensive religious revival is extremely small compared with the vast numbers that attend the meetings. All sorts and conditions of men, embracing almost every creed, are attracted, to some extent, by the outward exhibition of revivalistic fervour, and they are frequently induced, against their will, to listen to the preacher. A thoughtful observer, regarding such a gathering from a psychological aspect, is struck by the immense power possessed by spiritual forces over the material, and, perchance, the critic himself, wholly disarmed by the simple Gospel narrative, lays open, it may be for the first time, the innermost recesses of his being to the compelling influences of the Divine.

Our Foreign Correspondents' Column.

FOR many years one of the leading features of THE MEDICAL PRESS AND CIRCULAR has been the weekly letters from foreign medical correspondents. Those who peruse those communications week by week need not be told that they often contain scientific information of a valuable character.

In many instances the fruits of progress in other countries, when conveyed through the medium of an intelligent correspondent, throw a fresh light on home work, and furnish pabulum of a solid yet stimulating and refreshing kind. On page 61 of our present issue will be found, for instance, an interesting note on the rare condition of hydronephroma. A recognition of the salient points of the metastatic growths therein mentioned may afford a key to otherwise obscure processes. The full indexing of these subjects for future reference is not an easy matter. Readers, however, who keep an eye on our foreign correspondence will most likely find themselves now and then repaid by the discovery of information upon some point in which they are specially interested, for the range of subjects dealt with is of a most comprehensive nature.

Nasal Affections and Children's Diseases.

THE clinical examination of a sick child is generally fraught with difficulty that does not exist in the case of an adult. Obviously, the younger the child, the more tact and patience are needed during the physical investigation. The orifices of the body frequently furnish clues to diagnosis from mere inspection alone. In the case of the nose, such symptoms as sniffing, epistaxis or rhinorrhœa are sufficiently obvious to attract attention, and, moreover, parents will generally only be too ready to supply information upon these points. The habit of "picking the nose" is often made much of by the friends of the patient, and this sign is popularly supposed to be diagnostic of intestinal worms. The presence of intra-nasal disease itself, giving rise to local irritation, is apt to be overlooked under such circumstances, and the case is airily dismissed with a santonin powder. At the next visit, the nasal organ is still the centre of attention when the physician ventures, perhaps, to examine the nasal fossæ with a speculum. That he will frequently be successful in discovering some abnormality of the parts is the opinion of Dr. Louis J. Lautenbach, (a) of Philadelphia, who read a paper upon the need for a more careful study of the nasal fossæ in sick children before the annual meeting of the American Medical Association. It is contended that many infantile disorders are directly or indirectly produced through chronic affections of this part of the respiratory tract. Thus, disturbances of digestion and pharyngitis may arise from chronic obstruction of the post-nasal space or from a neglected atrophic rhinitis. The association of deafness with naso-pharyngeal catarrh is, of course, well recognised. Chronic bronchitis has frequently been relieved by a thorough overhauling of the nasal passages, and Dr. Lautenbach has drawn attention, two or three years ago, to the connection between nasal disease and an unequal curvature of the cornea, causing astigmatism. Foreign bodies are not infrequently discovered in the nostrils of children.

PERSONAL.

PRINCESS CHRISTIAN has consented to lay the foundation stone of a West Wales Consumption Sanatorium at Llanyfytter. The employées at the Pembroke Dockyard will probably support two of the twenty beds.

AMONG the passengers on board the SS. *Sobo*, which sailed for West Africa on the 31st ult., was Dr. R. E. M'Connell, member of the Liverpool School of Tropical Medicine, this being the fourteenth voyage for research purposes.

AT a joint meeting of the Cardiff Medical Society, on January 4th, it was decided to invite subscriptions towards the expenses incurred by Dr. Griffiths in defending the action brought against him by a patient. Dr. A. P. Fiddian, treasurer of the society, will receive any subscription sent.

To endow a bed in memory of his late wife, Sir Robert Harvey, of Trenowth, has given £1,000 to the Cornwall Infirmary, Truro.

AN illuminated address has been presented to Dr. T. J. Jefferson, J.P., by the Maxwell Lodge Oddfellows as a mark of gratitude for his services to them during the past forty years.

PROFESSOR NOTHNAGEL, of Vienna, Professor Pavlov of St. Petersburg, and Professor Marchiafava, of Rome are among the recently elected foreign members of the Royal Medical and Chirurgical Society.

THE Inaugural Dinner of the Association of Medical Diplomates of Scotland will take place at the Trocadero Restaurant, London, on February 14th. Tickets half a guinea each, may be obtained of the Hon. Sec. Dr. David Walsh, 18A, Hanover Street, London, W.

THE fire which took place recently at the Buck County Asylum was first noticed by Nurse Mary Kinsella, who was returning from night duty. To her presence of mind, aided by the Matron, Miss Millard, the prevention of a great disaster was due.

A RESIDENT of Esher, having offered £100 to the Royal Waterloo Hospital if four others would do the same, has been met by Sir Edgar Vincent with another £100.

It is announced that Dr. W. Heck, of Rheydt, Rhineland, is betrothed to Fraulein Bertha Krupp, of Essen, who is reputed to be the wealthiest heiress in Germany.

AT the quarterly meeting of the Council of the Royal College of Surgeons of England last week, a report was received regarding an offer made by Mrs. Macloghlin, of Southport, to found scholarships in memory of her husband, the late Mr. E. Percy P. Macloghlin, M.R.C.S., formerly in practice at Wigan, which was gratefully accepted. It is proposed in five years from his death, to give to the Royal College of Surgeons of England a sum of £10,000 for endowing these scholarships.

DR. H. TIMBRELL BULSTRODE has been appointed to represent the English College of Surgeons at the Conference on school hygiene to be held in London next month, under the auspices of the Royal Sanitary Institute.

DR. E. W. WHITE, who has just retired from the post of medical superintendent of the City of London Asylum, which he held for nearly twenty years, has been presented by the Visiting Committee with a gift of silver and an illuminated address. The presentation was made by Sir George W. Truscott, the chairman of the committee.

WE hear that Sir William Thomas Lewis has made donation of £1,000 to the Cardiff Infirmary.

MR. GEORGE HERRING, whose munificent donations to the Hospital Sunday Fund amount to over £50,000, has consented to identify himself more with the work, and was appointed to the Committee last week.

THE sum of £1,000 has been presented by Mr. Edward Heron-Allen to the Westminster Hospital to endow a bed in one of Dr. Murrell's wards in recognition of his valuable contribution to pharmacology and "Researches on the Action of Remedial Agents in the Treatment of Disease."

Special Correspondence.

[FROM OUR OWN CORRESPONDENT.]
SCOTLAND.

UNIVERSITY OF EDINBURGH.—During the past year the total number of matriculated students, including 317 women, was 3,000, the highest number reached for eleven years. The students enrolled in the Faculty of Medicine numbered 1,480, of whom 583 belonged to Scotland, 352 to England and Wales, 113 to Ireland, 74 to India, 238 to the Colonies, and 20 to foreign countries. The degrees of M.B., Ch.B., were conferred on 161 candidates, including 12 women; of M.B.C.M., on 4; and of M.D. on 61. Fifty-four graduates, including 6 women, received the special University certificate in diseases of Tropical climates. In response to the appeal made to the public for funds to aid in the development of the university, Sir Donald Currie has made the munificent gift of £25,000, which is to be known in the future as the Sir Donald Currie Lectureship Endowment Fund. Other contributions to the extension fund amounting to £15,000 have been intimated, including £5,000 from Sir John Jackson, to the Tait Memorial Fund for the encouragement of physical research. The University have purchased the Old City Hospital and Grounds from the Town Council, and the buildings thus acquired are to be adapted to the purposes of the natural philosophy and engineering departments. Although the Carnegie Foundation has not had an appreciable effect in increasing the number of students, it is noticeable that many take out more classes than they would probably otherwise have done. A lectureship in military subjects has recently been instituted in co-operation with the War Office; the course of instruction extends over three winter sessions. Dr. J. O. Affleck and Dr. C. B. Ker have been appointed University Lecturers in infective diseases, and a lectureship in the Practical application of anaesthetics has been instituted, to which Mr. T. D. Luke, F.R.C.S.E. has been elected. The additions to the library numbered 1973, being an increase of 700 over the previous year; the re-cataloguing of the library is now practically completed, 210,000 volumes in the general library, and several departmental libraries having been dealt with in the process. The question of printing the catalogue will have to be considered as soon as the alphabetical arrangement is complete, but meanwhile the printing of a short catalogue of some 25,000 volumes for the use of readers is proceeding, and will, it is hoped, be finished during the year. In the library itself a great improvement, both as regards space, and security from fire, has been the introduction of a system of steel shelving of the most approved type.

Correspondence.

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

PROPOSED STERILISATION OF CERTAIN DEGENERATES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.
SIR,—Every earnest worker at social problems deserves respect. Dr. Rentoul's earnestness is unmistakable, otherwise one might find it difficult to

refrain from ironical treatment of his writings on the above-named subject. What does Dr. Rentoul think would be the fate of anyone, who in the present state of the law should proceed to sterilise a degenerate without the consent of the patient? What the penalty might be under the criminal law may be uncertain; but there can be little doubt about the amount of damages an injured individual would be awarded by a British jury in an action in the civil courts. Sterilisation of degenerates would need the sanction of the law before it could be practised. Does Dr. Rentoul think such a project of law is anywhere within reasonable distance of the sphere of practical politics? Can he conceive of a Government introducing such a measure? Can he imagine the shouts of laughter that would greet the presentation of such a Bill by a private member? Every sensible member of Parliament, as well as every student of sociology, would at once suggest the necessity first of all of attacking the known causes of degeneracy. Syphilis, tuberculosis, rickets, drink, poverty, vice, crime—these are some of the chief causes of degeneracy, all mitigable or removable. Enforcement of the Public Health Acts thoroughly would in itself form a long step in this direction. In many or most districts these laws are largely neglected owing to the ignorance or selfishness of the men composing local authorities. The medical officer of health in many places is the ill-paid servant of vulgar men, and, being unsupported by public opinion, is unable to urge upon the authority, much less to ensure, enforcement of the law in his district. In most small urban, and in most rural districts, men of education and position decline to take office on the council, whilst the Local Government Board never interferes unless an epidemic or a similar emergency arises. Even in many villages within fifty miles of London, many of the poor are housed in a fashion as to sanitation and water supply which few of their wealthy neighbours would allow for many days in the case of their favourite horses. If Dr. Rentoul will direct his energy to rousing the conscience of the whole people by bringing before them the national perils which undoubtedly surround them through neglect of their duty as citizens, he will do some good. If the same amount of human energy, and of money—many millions annually—now devoted to attempts to convert the foreign heathen were directed wisely to solution of the social problem at home—to conversion of our own pagans and savages to a higher plane of civilisation—the need for sterilisation of degenerates, among other mitigating remedies for the symptoms of the foul social diseases of the age, would be soon put an end to.

I am, Sir, yours truly,
A STUDENT OF SOCIOLOGY.

Jan. 12th, 1905.

HOSPITAL FUNDS AND SMALL HOSPITALS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.
SIR,—Mr. Sewill, having appointed himself arbitrator, gives his considered judgment that the general hospitals are almost perfect, ignoring the waste of the £39,000 a year H.R.H. the Prince of Wales drew attention to. As I do not agree with him either in his self appointment as judge or with his finding, he accuses me of "confusion of thought with regard to the main issues."

These issues were twofold—(1) the necessity for the abolition of the special hospitals, and (2) the wickedness of advertising, when attempted by one outside the sacred ring. The latter I congratulate Mr. Sewill on having at last ceased to mention. As regards the first, I would ask Mr. Sewill to take perhaps the most evident case, what was the position of ovariectomy in the general hospitals before Spencer Wells established the operation in London? I am old enough to remember when there were no special throat, ear, eye, or skin departments in many general hospitals, and I fail to see why, because the general hospitals have been compelled to follow and make special departments, that this is a good reason for the abolition of the small hospitals.

Instead of a column of platitudes will Mr. Sewill, in support of his claim to almost perfection, answer my question about ovariectomy, and will he also tell us how he explains away the waste of £39,000 a year.

I am, Sir, yours truly,

OUTSIDER.

Obituary.

SIR JAMES LOUIS DONNET, K.C.B., R.N.,
M.D.St. AND., L.R.C.S.Ed.

THE death is recorded of Sir James John Louis Donnet, K.C.B., Inspector-General of Fleets and Hospitals, R.N., retired, on the 11th inst., at the residence of his daughter, at Bognor, in his eighty-ninth year. Sir James Donnet was the son of Surgeon Henry Donnet, R.N., by his marriage with Elizabeth, daughter of Mr. John Moore, of Dublin, Philadelphia, and Gibraltar. He was educated in Paris, Edinburgh, and London, and joined the Navy as an assistant surgeon in 1840. In this rank he was present in the "Vesuvius" at the operations on the coast of Syria and at the siege and fall of St. Jean D'Acre, and he had charge of the R.M. Hospital at Acre after the fall of that place. One notable service was with the Arctic expedition of 1850-51, in the "Assistance," when the first footprints of Franklin were discovered, and then, three years later, as senior medical officer of the flagship "President," at the attack, during the Russian War, of the allied squadrons on the stronghold of Petropaulowski, in Kamschatka. He was promoted to the rank of deputy Inspector-General in 1867, and to that of Inspector-General in 1875, and in those ranks, before his retirement in 1876, he filled many important posts in or connected with the medical service of the Navy. His many services were recognised in 1870 by his appointment as honorary surgeon to Queen Victoria, in 1878 he was awarded a good service pension, in 1893 he became an honorary physician to Queen Victoria, and in 1897 he received the honour of a Knight Commandership of the Bath. At the time of his death Sir James Donnet was an honorary physician to the King. Sir James married in 1852 Eliza (who died in 1903), daughter of Mr. James Meyer.

OGILVIE GRANT, M.B.Ed., D.P.H., L.R.C.P.Ed.,
OF INVERNESS.

WE regret to announce at the early age of forty-eight years, the death of Dr. Ogilvie Grant, medical officer for the county and burgh of Inverness, at the residence of his brother, Maryhill, Inverness, on the 9th inst. Dr. Ogilvie Grant was educated at Inverness Royal Academy, Edinburgh Academy, and in the University of that city, he distinguished himself in English literature, classics, and mathematics, afterwards bringing his medical studentship to a close with the degree of M.B., C.M., in 1881. After some useful Continental experience, Dr. Grant started a private practice in Inverness, and soon took a prominent part in the professional and intellectual life of the town.

GEORGE FREDERICK CHADWICK, L.R.C.S.,
L.R.C.P., L.F.P.S.Glas., OF STOCKPORT.

WE regret to announce the sudden death of Mr. George Frederick Chadwick, a well-known Stockport medical practitioner, on the 7th instant. He complained of indigestion, and died before a doctor could be sent for. Deceased was educated at Owens College, Manchester, and in 1891, took the diploma of L.R.C.S., L.R.C.P.Ed., and the L.F.P.S.Glasgow.

EUBULUS WILLIAMS, M.D.St. AND., M.R.C.S.ENG.
L.S.A., OF BRISTOL.

WE regret to announce the death of Dr. Eubulus Williams, the well-known homœopathic practitioner, at his residence, Clifton, on the 9th inst., in his seventy-fourth year. Dr. Williams was born at Williton, Somerset, fifth son of the late Mr. Joseph Williams. He was educated at Taunton College, and matriculated

at London University, afterwards becoming a student at Guy's Hospital. Soon after taking his surgeon's degree, in 1853, Dr. Eubulus Williams was appointed house surgeon to the Reading Hospital, and in 1855 was elected medical superintendent to the Dundee Royal Infirmary. In 1858 he began practice in Bristol, and joined in working a dispensary in St. James's Square, Bristol, for diseases of women and children, and when the dispensary was merged in the Children's Hospital. Dr. Williams was elected on the surgical staff. On embracing homœopathic principles, he gave up his connection with the Children's Hospital, but was re-elected senior surgeon in 1863.

BRIGADE-SURGEON JAMES DOW SAINTER, who joined the Army in 1859, and served throughout the China Campaign of 1860, died recently at Craigellachie at the age of seventy, having retired from the Army in 1880.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

A QUARTERLY MEETING of the Council was held at the Royal College of Surgeons on Thursday, the 12th inst., Mr. John Tweedy, President, in the chair. Mr. Bernard Pitts, F.R.C.S., made the required declaration and was re-admitted a Member of the Court of Examiners. The death of Mr. A. Quarry Silcock, a Member of the Court of Examiners, was reported, and a vote of condolence was passed with his widow and family. The President stated that the vacancy in the Court of Examiners thus occasioned would be filled up at the next meeting of the Council in February, together with the vacancy occasioned by the expiration of the period of office of Mr. W. H. A. Jacobson.

Diplomas of Fellowship were issued to John Hay Burgess, M.B.Lond., and Noel Everard Waterfield, M.B.Lond.

Diplomas of Membership were issued to the following candidates:—Wilfred Edward Brierley (Worcester), Joseph William Evans (Charing Cross Hospital), Edward Ernest Mossop (Cape Town), and Alfred Spitteler (Bombay).

Diplomas for the Licence in Dental Surgery were issued to the following candidates:—Alexander Henry Craig (Belfast), Herbert John Tindall (Ipswich), and Henry Harrison Tomlinson (Cheshire).

A report was received from the President and Vice-Presidents regarding an offer made by Mrs. Macloghlin, of Southport, to found Scholarships in memory of her late husband, Mr. E. Percy P. Macloghlin, M.R.C.S., formerly in practice at Wigan.

Mrs. Macloghlin's offer is made in accordance with the intention and expressed desire of her husband, and she proposes in five years from his death, to give to the College a sum of £10,000 for the purpose of endowing these Scholarships, which are intended to assist young students in need of financial help to proceed with their professional studies.

The Council gratefully accepted Mrs. Macloghlin's munificent offer, and agreed to administer the Trust which had been arranged by the President and Vice-Presidents in consultation with Mrs. Macloghlin.

Dr. H. Timbrell Bulstrode was appointed to represent the College at the Conference on School Hygiene arranged by the Royal Sanitary Institute to be held in London next month.

Mr. Edmund Owen presented to the College, on behalf of Mr. Edward Atkinson, M.R.C.S., of Leeds, six saws invented and used by William Hey for operations on the skull, and a vote of thanks was accorded to Mr. Edward Atkinson for his very interesting gift.

La Revue Internationale de la Tuberculose, edited by Dr. S. Bernheim, Paris, and published for the last three years in French, Italian, and Spanish, will, from January, 1905, be edited in English as well in order to satisfy the request of a great number of English and American medical men.

ARRANGEMENTS have been made by the Hamburg-American Steamship Co., to organise sea voyages for the benefit of the tuberculous. The first boat sails at the end of the month.

Medical News.

Medical Sickness and Accident Society.

THE usual monthly meeting of the Executive Committee of the Medical Sickness, Annuity and Life Assurance Society was held at 429, Strand, London, W.C., on the 30th ult. There were present Dr. de Havilland Hall, in the chair; Dr. J. Pickett, Dr. W. Knowlesley Sibley, Mr. H. P. Symonds, Dr. Fredk. S. Palmer, Dr. J. W. Hunt, Dr. M. Greenwood, Dr. St. Clair B. Shadwell, and Dr. J. B. Ball. The accounts presented showed that the sickness claim account has been much increased by members suffering from influenza. The claims have been of short duration, although numerous, and the total amount in 1904 will be found satisfactory. The bonuses at age of sixty-five, resolved on at the last general meeting, have been paid, about one thousand pounds having been disbursed in this manner. This bonus has been an agreeable surprise to most of the recipients, whose letters show how greatly they have appreciated it. Prospectuses and all particulars on application to Mr. F. Addiscott, Sec., Medical Sickness and Accident Society, 33, Chancery Lane, London, W.C.

The Pharmaceutical Society of Great Britain.

THE council of the Pharmaceutical Society of Great Britain has resolved that the Pharmacy Acts Amendment Bill shall be introduced into the House of Commons at the earliest opportunity. The council proposes a clause to prohibit absolutely the use of the title of "chemist" or "druggist," or "chemist and druggist" by limited companies, and to prevent such companies carrying on the business of a chemist and druggist unless one of the directors of the company, and all assistants in charge of branch shops, are duly registered chemists. Further, anything which would be an offence under the Pharmacy Acts if committed by an individual, will, according to this clause, be an offence for which all the directors of a limited company will be liable if done on behalf of the company. The Bill will probably be introduced by Mr. T. Lough, M.P., and a large number of members on both sides of the House have already promised their support.

Hygiene and Physical Degeneration.

AN interesting meeting was held in Dublin on the 9th inst., under the auspices of the Irish Association for the Prevention of Intemperance, when Professor Sims Woodhead delivered a lecture on the question, "How Far is Physical Degeneration the Result of Bad Hygiene and Intemperance?" Without committing himself as to whether there is any deterioration of the physique of the people really going on, the lecturer made the safe assertion that there is ample room for improvement. The secret of physical and intellectual fitness was nutrition, and the conditions of good nutrition were the conditions of good hygiene. Of these the most important were good air and wholesome food. Alcohol, by its interference with the growth and nourishment of the cells of the body, exerted a damaging influence on vitality. In particular, alcoholism predisposed towards phthisis, and was an important causal factor in regard to insanity. He noticed with satisfaction the diminution in the use of alcohol in the treatment of the sick, being himself somewhat sceptical of its usefulness under any conditions. Dr. James Little, who presided, contrasted the physique of British workmen with that of the workmen of Berlin and the North of Germany, to the advantage of the latter. He believed that our people are steadily degenerating. Sir Lambert Ormsby, who also spoke, drew attention to the need of the working classes of our great cities for better housing, and urged the establishment of gymnasia and places of healthy amusement as counter-attractions to the public-house.

Society for Relief of Widows and Orphans of Medical Men.

A QUARTERLY Court of the Directors of the above Society was held at 11, Chandos Street, W., on January 11th, Mr. Christopher Heath, President, in

the Chair. The President announced the death, on January 5th, of Mr. J. B. Blackett, who had filled the office of Secretary to the Society for thirty-seven years, and the following resolution was unanimously passed: "That this Court has received with deep regret the announcement of the death of Mr. Joseph Blackett, M.R.C.S., who has so ably filled the office of Secretary to the Society for the Relief of Widows and Orphans of Medical Men since 1868. The Court desires to place on record its appreciation of the valuable services of Mr. Blackett to the Society, and of his unvarying kindness to and consideration for the annuitants of the Charity; and wishes to convey to his family its sincere sympathy in their bereavement." Fifty-two widows and 16 orphans had received a Christmas present, amounting in all to £574, in addition to their annuities. A sum of £1,293 was allotted in payment of the half-yearly grants to the annuitants. Four new members were elected, and one new application on behalf of a widow was received. Four applications for the vacant office of secretary were received and considered, and Mr. Edward J. Blackett, M.R.C.S., L.R.C.P., was elected to succeed his father as secretary.

The British Gynaecological Society.

AT the annual meeting of this Society, held on Thursday, January 12th, 1905, the election of the officers and council for the current year resulted as follows:—

Hon. President.—R. Barnes, M.D., F.R.C.P., F.R.C.S.

President.—William Alexander, M.D., M.Ch., F.R.C.S. (Liverpool).

Vice-Presidents.—E. Stanmore Bishop, F.R.C.S. (Manchester), Bedford Fenwick, M.D., M.R.C.P. (London), F. Bowreman Jessett, F.R.C.S. (London), R. P. Ranken Lyle, B.A., M.D., B.Ch. (Newcastle-on-Tyne), Sir A. V. Macan, M.A., M.B., M.Ch., M.A.O., F.R.C.P. (Dublin), J. Jameson Macan, M.A., M.D. (London), H. Macnaughton-Jones, M.D., F.R.C.S.I. (London), Christopher Martin, M.B., C.M., F.R.C.S. (Birmingham), J. A. Mansell-Moullin, M.A., M.B., M.R.C.P. (London), Thomas Oliver, M.A., LL.D., M.D., F.R.C.P. (Newcastle-on-Tyne), Heywood Smith, M.A., M.D., M.R.C.P. (London), and W. Dunnett Spanton, F.R.C.S. (Hanley).

Hon. Treasurer.—W. H. Simon, M.D., F.F.P.S. (London).

Council.—T. Gelston Atkins, B.A., M.D., M.Ch. (Cork), N. T. Brewis, M.B., C.M., F.R.C.P., F.R.C.S. (Edinburgh), G. Roe Carter, M.R.C.P.I. (London), Sir J. Halliday Croom, M.D., F.R.S.E. (Edinburgh), William Duncan, M.D., M.R.C.P., F.R.C.S. (London), F. Edge, M.D., M.R.C.P., F.R.C.S. (Wolverhampton), George Elder, M.D., C.M. (Nottingham), T. J. English, M.D. (London), J. H. Ferguson, M.D., F.R.C.P., F.R.C.S. (Edinburgh), Clement Godson, M.D., M.R.C.P. (London), Arthur Helme, M.D., M.R.C.P. (Manchester), R. J. Kinkead, A.B., M.D. (Galway), J. Macpherson Lawrie, M.D. (Weymouth), Samuel Lloyd, M.D. (London), John Padman, M.R.C.S. (London), Ernesto Pestalozza, M.D. (Florence), J. J. Redfern, M.A., M.D., M.Ch., M.A.O. (Croydon), Charles Ryall, F.R.C.S. (London), R. T. Smith, M.D., M.R.C.P. (London), J. H. Swanton, M.A., M.D., M.Ch., M.R.C.P. (London), J. W. Taylor, M.Sc., M.D., F.R.C.S., (Birmingham), W. Travers, M.D., F.R.C.S. (London), H. F. Vaughan-Jackson, M.R.C.S., L.R.C.P. (Potter's Bar), and Hugh Woods, B.A., M.D., B.Ch., M.A.O. (London).

Editor of the Journal.—J. J. Macan, M.A., M.D. (London).

Assistant Editor.—J. Hutchinson Swanton, M.D.

Hon. Secretaries.—Sol Jervois Aarons, M.D., C.M., M.R.C.P., and Smallwood Savage, M.A., M.B., B.Ch., F.R.C.S.

Auditors.—C. H. Bennett, M.D., and F. A. Purcell, M.D.

Trustees of the Property of the Society.—G. Granville Bantock, M.D., F.R.C.S., R. S. Fancourt Barnes, M.D., F.R.S.E., and Clement Godson, M.D., M.R.C.P.

Notices to Correspondents, Short Letters, &c.

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

ORIGINAL ARTICLES or **LETTERS** intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

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 re-forwarding from office to office. When sending subscription^s 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.

ET OFFERA.—We think that before legal proceedings are taken another attempt should be made, preferably by a mutual friend, to adjust the matter in dispute.

M. D., F.R.C.S.—The dislocation of their medical practice caused by the attendance of medical men at the Law Courts is well known to the judges and barristers; and the latter, in agreement with the solicitors of the case, generally do their best to minimise the inconvenience which may arise. Our correspondent, therefore, should place his position before the latter, and request the favour of being only summoned to attend at the last moment necessary for his evidence.

PUBLIC HEALTH.—We have never heard of any such patent. But inquiry might be made at the Patent Office.

GENERAL PRACTITIONER.—Adenoids are very rare in late life. A case, however, has been recorded in an old man of 70 years.

LUMBRICATE.—Our correspondent had better seek the advice of an ophthalmic surgeon.

M.D. Lond.—Yes, as soon as the report reaches us.

BROMATIS (Bolton).—In answer to your query we would advise you to look up the admirable "Practice of Medicine" recently edited by Dr. Bain. You will find there a short but clear account of the many bacteria commonly met with in the human mouth. Of these several are pathogenic, such as staphylococcus pyogenes aureus and albus; streptococcus pyogenes, diplococcus pneumoniae and micrococcus tetragenus. In addition, there are of course a number of adventitious pathogenic organisms.

EMERITUS.—We are surprised to hear that in the local institution you mention the possession of an English qualification is obligatory on all members of the medical and surgical staff. The exclusion thereby of Scotch and Irish qualifications inflicts a great and undeserved injustice upon a large number of medical men. We feel sure that if this matter were brought dispassionately and clearly before the governors of the charity they would not tolerate so great an anomaly, especially as it excludes from important posts those who are in many cases their own medical attendants. It would be well to call together the Scotch and Irish diplomates of your neighbourhood to consider the question. In your own case we should advise you to join the newly formed Association of Scotch Diplomates.

F. K. BROWN.—(1) Write to the Secretary of the College, who will give you the requisite information. (2) Apply to the Local Government Board.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JANUARY 18th.

SOCIETY OF ARTS (John Street, Adelphi, W.C.).—8 p.m. Paper:—Capt. L. James: Wireless Telegraphy and War Correspondence.

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY (20 Hanover Square, W.).—5.30 p.m. Paper:—Dr. C. W. Buckley (Buxton): Climatology from a Medical Standpoint.

ROYAL METEOROLOGICAL SOCIETY (Institution of Civil Engineers, Great George Street, Westminster, S.W.).—7.30 p.m. Ordinary Meeting. 7.40 p.m. Annual General Meeting. Election of Officers and Council for the ensuing year. Address:—The President (Capt. D. Wilson-Barker): The Connection of Meteorology with other Sciences.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. G. L. Obesale: Clinique. (Surgical.) 5.15 p.m. Dr. D. Grant: The Treatment especially Intra-Nasal, of Suppuration in the Nasal Sinuses.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—5 p.m. Dr. Beppard: Practical Medicine.

CENTRAL LONDON THROAT AND EAR HOSPITAL (Grey's Inn Road, W.C.).—5 p.m. Demonstration:—Mr. Nourse: Nasal and Aural Accessory Sinuses.

THURSDAY, JANUARY 19th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC, 22 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Mr. J. Clarke: Recent Improvement of Painful and Deformed Feet.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Dr. A. E. Giles: Uterine Displacements.

MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST (7 Fitzroy Square, W.).—8 p.m. Lecture: Sir William Broadbent: The Examination of the Heart and what may be learned from it. (Post-Graduate Course)

FRIDAY, JANUARY 20th.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN (11 Chandos Street, W.).—5.30 p.m. Cases and Specimens will be shown by Dr. W. H. Kelson, Dr. A. Morrison, Dr. L. Guthrie, Mr. G. Pernet, Mr. F. Jaffray, Mr. D. Armour, Dr. E. Pritchard, Dr. J. G. Emanuel, and Dr. G. Carpenter. Paper:—Mr. D. Drew: On a Case of Vesical Urteral, and Renal Calculus in a Child.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.). 4 p.m. Dr. St. Clair Thomson: Clinique. (Throat.)

MONDAY, JANUARY 23rd.

ODONTOLOGICAL SOCIETY OF GREAT BRITAIN, (20 Hanover Square, W.).—On Monday Jan. 23rd, A Casual Communication by Mr. J. B. Parfitt, L.R.C.P., M.R.C.S., L.D.S. Eng., on "An Extreme Case of Saddle-shaped Arch." Paper by Mr. E. Denison Pedley, F.R.C.S.E.D., M.R.C.S., L.D.S. Eng., on "The Relationship between Dental and other Diseases."

Vacancies.

Ashton-under-Lyne, District Infirmary and Children's Hospital.—Resident House Surgeon. Salary £180 per annum, with board, washing and lodging, gas, fire, and attendance. Applications to the Honorary Secretary, Leonard Bottomley, 120 Stamford Street, Ashton-under-Lyne.

East Sussex County Asylum, Hellingly.—Senior Assistant Medical Officer. Salary £200 per annum, with board, lodging, washing and attendance. Applications to Reginald Blaker, Clerk to the Visiting Committee, 211, High Street, Lewes.

Chester General Infirmary.—House Surgeon. Salary £100 per annum, with residence and maintenance in the house. Applications to the Chairman of the Board of Management.

County Asylum, Rainhill, near Liverpool.—Assistant Medical Officer. Salary £150 per annum, with furnished apartments, board, attendance, and washing. Applications to the Medical Superintendent.

Monmouthshire Asylum, Abergavenny.—Junior Assistant Medical Officer. Salary £150 per annum, with board, lodging and washing. Applications to the Medical Superintendent.

Newcastle-on-Tyne Dispensary.—Visiting Medical Assistant. Salary £160 per annum. Applications to the Honorary Secretary, Joseph Carr, 41 Kosley Street, Newcastle-on-Tyne.

National Hospital for the Paralysed and Epileptic, Queen's Square.—Nervous Diseases Research Fund.—Director of Neuro-pathological Research. Salary £250 per annum. Applications to Edgar Speyer, Esq., Chairman of the Fund, National Hospital for the Paralysed and Epileptic, Queen's Square, W.C.

Manchester Hospital for Consumption and Diseases of the Throat and Chest.—Resident Medical Officer. Salary £100 per annum, with board, apartments, and washing. Applications to C. W. Hunt, Secretary.

Dudley Dispensary.—Resident Medical Officer. Salary £150 per annum. Applications to Henry C. Brettell, Hon. Sec. Jaffray Branch of the General Hospital, Gravelly Hill, near Birmingham.—Resident Medical and Surgical Officer. Salary £170 per annum, with board, residence and washing. Applications to the House Governor, General Hospital, Birmingham.

Parish of St. Giles, Camberwell.—Assistant Medical Officer at the Infirmary, Brunswick Square, Camberwell. Salary £120 per annum, with apartments, board, and washing. Application to the Medical Superintendent at the infirmary.

Appointments.

BREWSTER, J. M., L.R.C.P.I., L.S.A., Certifying Surgeon under the Factory, Act for the Biddington District of the County of Nottingham.

CLAPP, GEORGE TUCKER, M.B. Cantab., M.R.C.S., Medical Officer to the Exeter Post Office Staff.

CORNER, EDWARD M., M.B. Camb., F.R.C.S., Consulting Surgeon to the Bowes Park Cottage Hospital.

COWIE, J. A., B.A., B.Sc. N.Z., M.B., Ch.B. Glasg., M.R.C.S. Eng., L.R.C.P. Lond., Assistant House Surgeon to the Royal Devon and Exeter Hospital.

LEES, HAROLD C., M.B. C.S., L.R.C.P. Lond., M.B., B.S. Lond. Junior House Surgeon at the Blackbura and East Lancashire Infirmary.

MACKEZIE, H. VALENTINE, M.D., C.M. Edin., Honorary Ophthalmic Surgeon to the Moretonhampstead (Devon) Cottage Hospital.

Births.

PRIDIE.—On Jan. 12th at Wansford, Northamptonshire, the wife of Hugh Hampden Pridie, M.B., of twin daughters.

Marriages.

WHOLEY—HUNTER.—On Jan. 7th, at St. Martin's-in-the-Fields, Thomas Wholey, M.B., Dunelm, to Agnes Eveline, daughter of the late Lowther Hunter, Esq., and of Mrs. Hunter, of Rockville, Burlington Place, Eastbourne.

Deaths.

MANBEY.—On Jan. 11th, at Brookfield, London Road, Southend-on-Sea, Georgianna Manbey, widow of late George Manbey, Esq., M.R.C.S.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX"

VOL. CXXX.

WEDNESDAY, JANUARY 25, 1905.

No. 4.

Original Communications.

TWENTY YEARS OF OPERATIVE GYNÆCOLOGY. (a)

By PROFESSOR JOHN W. TAYLOR, M.D.,
F.R.C.S., &c., &c.,
Birmingham.

AFTER reviewing the progress of gynæcology during his year of office, the work of the Society, and the losses sustained by the profession from the deaths of eminent men, Professor Taylor said:—

Twenty years ago I joined you as a Foundation Fellow, and for twenty years I have been engaged in the practice of operative gynæcology. The table which I show gives a yearly record of all the abdominal sections I have performed on women during this period. The cases are strictly consecutive and the total number of sections is 1,291. The total mortality is 85, or 6·5 per cent.

On examining this mortality more closely I notice that a large proportion of the deaths were unavoidable, or were only indirectly due to the operation. One patient was attacked by apoplexy during anæsthesia, and eventually died from this, the operation (a resection of bowel) being perfectly satisfactory, as proved by *post-mortem* examination. Five of the patients suffering from acute perforative peritonitis; (b) four with intestinal obstruction were almost moribund at the time of operation, and many others (no less than 22) suffering from malignant disease, died rather from the original affection than from the operation, exploratory or otherwise, which was undertaken for their possible relief.

There are, however, certain other cases of failure which are and must remain a trouble to me, especially some early cases of sepsis after operation, some cases of secondary hæmorrhage, and, finally, some cases of difficult myoma operated upon during a time of transition, when the old operation of the clamp (perfected so far as it could be, I think, by a method of my own) was slowly giving way to the more modern and better methods of supra-vaginal amputation and pan-hysterectomy.

I did the (then) more difficult operation under very bad conditions, and my work suffered accordingly. If I and some of my patients had been able to wait for riper experience, I think the result in all of these cases might have been different. In one instance of a neglected myoma, I met with a greater amount of peritoneal displacement than I have ever seen or read of elsewhere, and it may perhaps be of service to record it here. The descending and transverse colon had been raised by the growth of an enormous tumour of the left side so that the transverse colon passed from right to left across the middle of the back of the tumour,

and the omentum formed a cap covering the summit of the growth and falling to some extent over its anterior surface. The almost irresistible inference at first was that the transverse colon was adherent to the back of the tumour. It was indeed closely attached everywhere to the tumour, but by peritoneal displacement, and not by adhesion.

In concluding here my references to the record of deaths, I think I am justified in noting that I have, I hope, learnt something from my failures, and that in spite of, or rather perhaps by virtue of, advancing years, and by virtue of some teachableness, my last five or six years of work have been my best years, and the last year is, on the whole, the best of all, giving, with a fair proportion of grave and important work, a death-rate of only about 1 per cent. This, I think, may deservedly give more weight to the remarks I wish to make on the progress of my practice. I can remember the faulty septic days, when from ignorance little or nothing was left undone that could encourage sepsis; the days of more or less empirical asepsis, when men were stumbling as if blindfold towards a path of safety; and the later years, when the darkness had lifted and one could see the plain outlines of the road which led towards the goal. All this time, during which I have myself been working, has been a time of searching for better methods of asepsis and a time of experiment in this direction.

The first dawning for me (I speak for myself) came with the definite recognition of the mathematical value of heat in sterilisation. The full grasp of this all-illuminating fact made the continued use of the old sponge impossible, and this was cast aside for the artificial sponge of gauze which, like the instruments, the towels and the dressing, could be subjected to a really sterilising bath or atmosphere.

Next to this, there is nothing which has given me so much satisfaction and confidence in all my later work as the adoption of the permanganate of potash and oxalic acid method of Kelly for the sterilisation of the hands of myself, assistant, and chief nurse or nurses. This method, first introduced at Sparkhill by my colleague, Mr. Martin, and supplemented in my own practice by the additional use both of methylated spirit and solution of the red iodide of mercury—a method employed, not only at the time of operating but immediately after touching any case or dressing that may leave serious contagion behind it—has proved a much more trustworthy proceeding than anything I had previously tried. It is not difficult to obtain, the drugs are common and inexpensive; it requires no measurement, the solutions are saturated; it is not hurtful to the hands, as are all the carbolic acid compounds and derivatives, and I do not think that since I have regularly employed it I have had any case of sepsis that can be reasonably referred to hand infection. I believe if this method were generally used by practitioners and nurses, not only before the operative work of a confinement, but immediately after any dangerous contact in ordinary practice, it would be possible to eliminate the danger that undoubtedly still remains in private midwifery practice.

(a) The President's Valedictory Address, delivered at the Annual Meeting of the British Gynæcological Society, January 12th, 1905.

(b) One of these was a case of Cæsarian section. The infant is still living.

Perhaps you will pardon a palpable digression if I briefly relate an instance which seems to throw some side-light on the value of the method.

The children of a practitioner who was well known to me had suffered for several years from tinea tonsurans. They had received the best dermatological advice and treatment, but the disease persisted and threatened to injure or stop their education. The skin was unbroken, and I suggested that the method I used for my hands should be applied to the children's heads. This was done thoroughly, and within a few months no trace could be found of the complaint.

This is, of course, only a single instance, but others, who have more opportunity than I have of testing its value may be inclined to employ it further.

Next to the use of prolonged boiling and steaming for the sterilisation of everything necessary to the operation that can be so treated, and to the employment of the fortified Kelly's method for the hands, I know of no change which has been of greater service in my work than the discarding of the comprehensive single short ligature—like the Staffordshire knot—for the control of the pedicle or broad ligament and the use, instead of this, of a series of finer interlocking chain-ligatures.

These, if of silk, can be readily made aseptic by boiling in biniodide solution, so that every vessel can be controlled by its own sterilised ligature with but little or no tissue intervening, and this without causing any tension or dragging. In this way I am convinced the operator can best ensure himself against any danger of subsequent hæmorrhage.

I generally use a sharp, widely-curved needle of sufficient size to carry the No. 3 or No. 4 ligature silk easily. I thread it with a long length of silk and pass the needle through the broad ligament close to the ovarian vessels. One strand of the double silk is then cut, forming the ovarian ligature. The remaining strand is pulled further through the eye of the needle and the needle passed back through the broad ligament near to, but not including, the uterine vessels. The needle is cut off, leaving two further ligature loops, one for the uterine vessels and one for the middle of the broad ligament. The ligatures are interlocked and the pedicle tied in a chain of three ligatures. More may, of course, be used if this is considered advisable.

Closely connected with the use of this method of ligature is the employment of finer silk. Obviously, if but little beyond the vessel is enclosed in the ligature, finer silk may be used with perfect safety, and I employ this extensively both for the ligation of vessels and for the suture of peritoneum and fascia in the closure of the abdominal wound.

In fact, for many years now, I have used nothing but silk and silkworm-gut, finding that the finer sizes of the silk can be adequately sterilised by half an hour's boiling in biniodide solution, and that in time they are as perfectly absorbed as catgut.

Bearing, I believe, on the same point of a septic ligature is the interesting question of what has become of the lost disease "pelvic hæmatocele," or, as some prefer to call it, "broad ligament hæmatoma." Years ago, it was one of the commonest complications of the convalescence after operation. In our own hospital I remember the time when four or five patients were lying side by side, and all suffering from this same affection. Now it has so universally disappeared that I can easily imagine a student and observer of the present day hesitating to accept the experience of the older ovariologists on this subject. What is the cause of its disappearance? Many appear to have thought that the hæmatocele was secondary to some puncture of a vessel in the broad ligament due to the use of a sharp-pointed needle (though the favourite time of its onset was not until nine or ten days after operation), and that the accident was to be prevented by using a blunt pedicle needle. In the practice of several, the change in the use of the needle has been coincident with the disappearance of the tumour, but I believe it has been simply a coincidence.

As I have already said, I have largely gone back to the use of a sharp-pointed needle, but without finding any

recurrence of the hæmatocele. In the older days, I think the silk used for tying the pedicle was often septic, and a slow process of ulceration occurred, opening the vessels about a week or so after the date of operation.

In turning now to the consideration of special operations, I notice, first, that the removal of the uterine appendages for myoma has slowly given way in my practice to the operation of hysterectomy, both abdominal and vaginal, but I have not entirely given up the older operation. As I have, however, quite recently published my opinions on the choice of operation in myoma (a) there is no necessity for me to refer to it again, and I pass on to notice the marked change which has taken place in my practice regarding the removal of the appendages for tubal disease, and especially for disease due to gonorrhœal salpingitis.

The cases of this, numbering 20 in 1893 and 17 in 1894, have come down to an average of 4 or 5 in the last five years, and that this is not due simply to the adoption of vaginal rather than abdominal methods of operating is seen at once on looking at the statistics of both operations. The change is, of course, due to the systematic carrying out of the mercury and iodine treatment in all cases of gonorrhœal salpingitis, as advised by myself in the paper I read before this Society in 1899.

Not only is the operation of removal needed much less often than formerly, if this be done, but when acute pyosalpinx makes an immediate operation imperative. A vaginal celiotomy, with thorough emptying of pus sacs and drainage, followed up afterwards by treatment with the biniodide of mercury, is, in many cases, a better method of treatment than that formerly adopted. I shall, however, have to refer to this again later. The after-history of these cases, so far as I have been able to follow it, compares very favourably with that of the older cases of extirpation.

It may be well to note here that the gist and point of my previous communication on this subject has been very insufficiently grasped by many who have spoken and written regarding it.

The value of the treatment has nothing whatever to do with syphilis or its possible complications. Experience appears to show that the biniodide of mercury has a direct curative power in gonorrhœa, being, probably, slowly destructive to the gonococcus in the tissues.

Perhaps another digression may tend to enforce this. A gentleman contracted a gonorrhœa after an impure connection, and thereafter was troubled with a slight gleet which he could not cure. He became engaged to be married, and for eighteen months resided abroad, where he somewhat naturally either forgot his slight ailment or at all events let it alone. He came back to England three or four months before his proposed marriage and sought the very best advice for the cure of his gleet. Instruments were passed, he was assured that he might marry with safety, but the discharge was slightly increased rather than diminished by treatment. He married and within six weeks his young wife was suffering from double pyosalpinx with dangerous symptoms of peritonitis and high pyrexia. Pus had already formed, and the disease was much too acute for medicinal treatment alone to stay its progress.

I opened the pouch of Douglas, separated the adhesions, evacuated pus on both sides of the uterus and carried out prolonged pelvic drainage with iodoform gauze, keeping the patient all the time under treatment. She made a slow but very perfect recovery, and during this time I saw a good deal of her husband. He was still suffering—almost imperceptibly—but still suffering slightly from his chronic gleet, and I thought I had sufficient grounds for suggesting that he might very reasonably adopt the same medical treatment as that given to his wife. Both patients recovered completely. This is nearly five years ago. Shortly after his wife's recovery they went abroad to live and have, I understand, enjoyed the best of health ever since. Only a

(a) "Journal of Obstetrics and Gynecology," August, 1904.

few weeks ago a doctor who was associated with me in the treatment of the case stopped me very kindly to tell me of the very good health that both had enjoyed since they were under our care.

Turning now to the question of inguinal colotomy, there is a small detail in its performance which has proved of very great comfort to myself, and as I have never seen it mentioned by others I think it may be of service to describe it. I generally use the method introduced, I believe, by the French surgeon, Reclus, in which a spigot of glass is passed through the mesentery under the bowel, and the loop of colon rides over this, protruding from the incision. I guard against any danger of further protrusion of bowel by sewing the peritoneum to the loop of bowel all the way round by a continuous suture of fine silk. This, however, is not the innovation to which I want to draw your attention.

The bowel, as I daresay you know, is usually divided by the cautery straight down to the spigot on the third or fourth morning. Now this, though practically painless, I found out to be a very awkward proceeding, on account of hæmorrhage. As many as five or six large arterial vessels spouted at the deepest part of the division. The loss of blood was considerable. The clumsiness of the proceeding was manifested to the patient who was quite conscious, and there was decided pain and discomfort in seizing the bleeding points and applying ligatures. This may be entirely avoided, I find, by passing a ligature on each side of the spigot at the original operation and tying off a small amount of mesentery. The tying of the mesentery cuts off the full blood supply from the line of opening, and makes the subsequent division of the bowel (right down to the spigot) practically bloodless.

Speaking generally and very broadly, conservative operations on the uterine appendages by abdominal section have rather disappointed me, the benefit derived being rarely worth the waste of the abdominal incision. In order to understand me rightly, however it may be necessary to define more exactly what I mean by conservative operations on the appendages. I include in this the undoing of adhesions involving the appendages, but not those specially involving intestine. Some of the most perfect successes I have had after operation have been due to the undoing of intestinal adhesions, which caused incomplete obstruction and were a daily source of pain and misery, but were accompanied by no tangible lesion on examination. These obviously are essentially intestinal operations whatever may have been the cause of the original inflammation.

Again, though a few cases of hysteropexy and ventrosuspension have been included for the sake of convenience in my tabular statement (and rightly included) as "conservative operations," they are not really conservative operations on the uterine appendages.

By this term I chiefly mean salpingostomies, partial excision of the ovaries, ignipuncture of the ovaries, and shortening of the ovarian ligaments, with or without separation of adhesions from above; and it is these operations which appear to me to have been rather disappointing.

Some patients have been relieved, but few or none have reported themselves as quite well afterwards. In some cases the operation has appeared to do harm, and I have had to remove the appendages afterwards. In one case (and one only) has the operation been followed by a pregnancy. None of these operations have been undertaken rashly. On the contrary, I do not know any class of case in which I have expended more thought, caution and ingenuity—if I may term it so—in treatment.

In some of these cases—and this is a point which needs consideration before operation is proposed—I think there has been throughout some fatal want of correspondence between the sexual organs or functions of husband and wife which vitiated every attempt to give the patient perfect comfort. The utero-vaginal prolapse, painful retroflexion and prolapse of ovaries met with in some of these cases seem to be due directly to this and to be consequently almost incurable.

It may be a hard thing to acknowledge and accept,

but some women are undoubtedly unfit for the married life which has fallen to their lot, and no mere operative change can make them otherwise. For simple prolapse of ovaries due to backward displacement, the operation which has given me the best final results is that of simple shortening of the round ligaments without needless opening of the peritoneum.

My vaginal operations call for some passing commentary. I was considerably attracted at first by anterior vaginal cœliotomy, but have now practically abandoned it, as I dislike all methods of uterine fixation. But posterior vaginal cœliotomy has, in many ways, become more and more attractive to me. I recognise that it has a very special field of its own, and this field of usefulness needs a better recognition by the general, as well as by the gynæcological, surgeon. There are, for example, certain conditions requiring operative treatment in which the vagina is so infinitely better as a route for approach and treatment that I have no hesitation in saying the neglect of this and the use of the abdominal route instead may amount to bad practice.

Acute pelvic peritonitis due to gonorrhœa, when the mischief is mainly behind the uterus, and abdominal distension, peritonitic vomiting and sleeplessness from pain form a triad demanding immediate interference, is, as I have already said, pre-eminently such a case—a case for vaginal, rather than abdominal, operation.

Again, in some cases of abscess due to appendicitis, the pus tends to collect in the pouch of Douglas, while adhesions root in the abscess from above. In such cases the proper method of exploration is by the pouch of Douglas, and a life may easily be unnecessarily sacrificed by choosing the more usual incision. Even in virgins and young children the possible advantage of this route should never be forgotten or overlooked. Again, a peri-rectal abscess in the pelvis—sometimes a long-neglected pyosalpinx—not infrequently opens at the upper limit of the abscess sac into the rectum and discharges into this by overflow rather than by emptying. The patient falls into a condition of hectic, and, as some instructive *post-mortem* preparations show, has often died of her disease. Such a pus sac may, of course, be occasionally removed successfully from above, but in the condition of which I am speaking, the better practice is immediately to freely open up the pus sac from the pouch of Douglas or directly from the vagina, and establish rational drainage from the most dependent portion of the abscess. This is generally sufficient to ensure a quick and permanent recovery.

Again, there are cases of thrombotic pyæmia after parturition in which suppuration occurs in the immediate neighbourhood of the thrombus. The disease may sometimes be stopped and the patient cured by evacuation of the pus and gauze drainage well carried out, either through the pouch of Douglas or between the layers of the broad ligament. Some cases of this kind (included in my list) I hope to report more fully at a later period. All of these cases can only be treated satisfactorily by vaginal surgery. With less certainty, but still with marked advantage in special instances, vaginal ovariectomy and vaginal enucleation demand increasing consideration. I find I have used these operations in 10 or (really) 11 cases, and, under certain conditions—as when a single cyst is blocking the pelvis during labour and preventing a delivery—I hold vaginal ovariectomy as more than a fair alternative, but distinctly superior to abdominal removal. The great point of the *technique* of posterior vaginal section, apart from the disinfection of the vagina, is the use of the iodoform-gauze drain behind the uterus instead of any suture of the incision. This applies to vaginal hysterectomy, unless the sutures and raw surfaces are turned well outside the peritoneum as in the German method. The gauze drain prevents any danger of intestinal adhesions at the site of operation and effectually guards the patient from an adherent retroflexion as a late result of the vaginal interference. I often leave the drain *in situ* for twelve or fourteen days before removal. The only time when I have chosen closure instead of drainage has been when doing a vaginal ovariectomy during labour.

In this retrospect of work, I have endeavoured to touch lightly, but firmly, on the main points which strike me as definitely calling for reference. With the exception of the two digressions, I have written as tersely as I could, and much in the same way as one talks to a friendly colleague in the operating-room, when the operation is over and the surgeon for a brief period opens his heart and strives to give, as best he can, a simple statement of his work and the reasons of his practice.

The comradeship of the Society may, I hope, be trusted to condone any want of circumstance or ceremony in this presentation of my address. We are all travellers in a common journey, travellers who, in the graphic words of Mr. Cunningham Graham (a)—“kicking at our horses sides, straining our eyes, keep pushing forward, stumbling and objugating on the trail.” But we are more than this—we are explorers in an unknown country, over and over again, where no man has trod before us, where no certain trail can be found for us to follow, and where the talk round the camp fire at night, when occasion calls for it, cannot well be less or more than plain, straight and truthful.

Before I vacate the Chair, gentlemen, I want to say for you all and for myself, some words of welcome to our new President, Dr. Alexander. He is well known all over the world, and nowhere perhaps could we have found one whose reputation, ability, and kindness of heart so naturally entitled him to the honour and confidence of his fellows. We welcome him most heartily as our President, we assure him of our loyalty and support, and wish him every happiness and success in this his year of office.

A CASE OF OXALIC ACID POISONING WITH DEATH FROM PNEUMONIA.

By WILLIAM MURRELL, M.D., F.R.C.P.,
Physician to the Westminster Hospital.

POISONING by oxalic acid is by no means uncommon, but the following case presents certain points of interest. Oxalic acid is used for cleaning straw hats and other similar purposes, it can be obtained without difficulty, and it is cheap. As a suicidal agent it is less popular than carbolic acid and preparations of opium, but it comes third on the list in the case of women, and fourth with men. This difference in order is due to the fact that whilst prussic acid, cyanide of potassium and oil of almonds, all of which kill rapidly, are often resorted to as lethal agents by men, they are less commonly employed by females.

A tailor, *æt.* 50, was brought to the hospital by the police on December 6th, 1904, at 4 p.m., having been found in the street collapsed and vomiting. He stated that half an hour previously he had swallowed in tea two pennyworth of oxalic acid—probably about two ounces—with suicidal intent. He had been partly paralysed on the right side for four months, had been long out of work, and had been tramping the streets in search of employment. He had been without food for twenty-four hours, but during the morning had had three pints of beer. He was seen in the casualty room by Mr. E. C. Johnson, the house physician, who gave him large doses of saccharated solution of lime as an antidote, and then washed out the stomach with a solution of carbonate of lime, until the fluid returned clear and free from odour. The diagnosis was established by the presence of oxalate of lime crystals in the vomited matter, and subsequently in the urine. On admission to the

wards he was in a condition of collapse, his temperature being below 95°. He was given at frequent intervals hypodermic injections of strychnine. He vomited a little blood, but there was no diarrhoea, and the mucous membrane of the mouth was not excoriated. On the following day the temperature gradually rose from 98.2° to 100.8°, and the pulse-respiration ratio, taken at intervals, was 120 to 24, 125 to 26, and 148 to 32. His lips were swollen, he complained of sore throat and difficulty of swallowing, and there was much tenderness in the epigastrium. He was too ill to be examined thoroughly, and hypodermic injections of morphine were given to allay the pain. On the 8th there was a similar variation in temperature, which rose from 98° in the morning to 100.8° at night, the pulse-respiration ratio being 156 to 30 and 146 to 32, and the pulse small and soft. There was very little cough and no expectoration. The urine was of sp. gr. 1010, was acid and free from albumin. It contained spermatozoa in large numbers. On the 9th the temperature at 4 a.m. was 97°, at 4 p.m. 99°, after which it gradually fell. The pulse-respiration ratio was 138 to 36 and 140 to 42. At the right base posteriorly there was some dulness and the breath sounds were bronchial. There was much tenderness over the abdomen, but there was no blood in the motions. The kneejerks were brisk, the right being exaggerated; there was no ankle-clonus. On the morning of the 10th, the temperature was 96.6°, the pulse was 124 and the respirations were 26. He vomited after taking a little barley and albumen water, and died at 12.10 on the morning of the 11th, having survived the dose 104 hours.

At the autopsy made by Dr. R. G. Hebb it was found that there was some congestion of the pharynx, and the mucosa of the œsophagus, especially in the lower part, was swollen and of a dark red hue, with well-marked superficial veins. All the coats were thickened. The mucosa of the stomach were thick, soft, velvety, and smooth. There were no signs of ulceration anywhere, and there was no gangrene. The intestinal tract was normal. The lungs showed pneumonic consolidation of the right lower lobe, and to a lesser extent of the upper lobe, with hyperæmia of the left lung. The kidneys were normal.

The case presents many points of interest. In the first place, what dose was taken? The patient stated that he purchased two pennyworth, and inquiry discloses the fact that oxalic acid is usually sold retail in penny packets containing an ounce, so that probably he took two ounces. As the minimum fatal dose is one drachm, this may be regarded as a large dose. Taking this into consideration, it is curious that there was so little damage to the œsophagus and stomach. This may be explained partly by the early vomiting, and partly by the fact that the dose was well diluted. It was taken, we were told, in tea obtained at a coffee-shop, and probably in a large cup, or possibly in a half-pint mug. The prompt administration of a strong solution of lime and the repeated washing out of the stomach must have removed much of the poison and have neutralised the caustic effect of the remainder. It will be remembered that the liquor calcis saccharatus contains 8 grains of lime in the fluid ounce, and the liquor calcis only half a grain in the ounce. The discovery of oxalate of lime crystals in the vomit is obviously a useful guide to diagnosis in

doubtful cases. In the first specimen they were very small, and required a one-twelfth for their detection, but in the second specimen, after more lime had been administered, they were much larger, and were readily recognised. The presence of oxalate of lime in the urine can hardly be regarded as diagnostic. It is difficult to say what, if any, importance should be attached to the cloud of spermatozoa in the urine. Is this peculiar to oxalic poisoning, or does it occur in every case in which a lethal dose has been taken? It will be remembered that in death by hanging there is often a discharge of seminal or prostatic fluid.

In some cases of oxalic acid poisoning symptoms referable to the nervous system predominate, but they were absent here. Moreover, the mental condition was clear from first to last, and there were no indications of delusions, or of any form of insanity. The duration of life was exceptional, although not unprecedented, for in one case it is said to have been prolonged for thirteen days. The immediate cause of death was pneumonia. Was this primary or was it secondary to the effects of the poison? The probabilities are that it was primary, an acute lobar pneumonia, possibly influenzal in origin. The patient was suffering from the intense depression which marks the onset of the disease, and this, combined with the long abstinence from food, probably induced him to take the poison. The elevation of temperature, which would normally have indicated the progress of the lung condition, was masked by the collapse induced by the drug.

An inquest was held. What should have been the verdict? Should it have been pneumonia or oxalic acid poisoning?

THE GULF STREAM MYTH AND SEASIDE RESORTS.

By JOHN KNOTT, M.A., M.D. Dub., M.R.C.P.

SOME time ago I read with interested attention the article headed "Some Questions in Seaside Climatology," by Dr. Alfred F. Street, of Westgate-on-Sea, in the issue of THE MEDICAL PRESS AND CIRCULAR for December 2nd, 1903, in which the writer graphically and forcibly indicated the conspicuous attractions which that seaside resort offers to those in search of a residence specially suited to the improvement and maintenance of health. Foremost among these appears to be, in the opinion of Dr. Street, "that it enjoys almost the full advantage of the Gulf Stream, . . . to which we in these islands are indebted for the advantage, that though London has the latitude of Labrador, it has a far higher mean winter temperature." I had almost learned to think—or hope—that by this time the spirit of the "Gulf Stream myth" had been successfully "laid"; at least, the data for the exorcism have been sufficiently long before the scientific world for their effective application. It is now several years since the accomplished meteorologist, Mr. Henry Maitland Watts, in a "popular" scientific article, pointed out to the reading world, "That the belief that the Gulf Stream is the sole cause of the mild oceanic climate of Western Europe is still held by millions to-day, that it is still taught in public schools in England and in the United States, and that, although it is absolutely without any foundation whatsoever, it should have come to have all the sacredness of a gospel truth, is a tribute to its

attractive statement by one man and the hypnotic influence of one book. . . . In consequence, the 'Gulf Stream myth,' fathered by Maury, persists, while the broader, grander and more reassuring facts as to climate and weather causation are viewed with suspicion, and make slight headway against the universal acceptance of a theory that gained its whole value from the way it was stated by a strong man in the transition period in the development of an inexact science. The essential facts are that the Gulf Stream as an ocean current ceases to exist, that is, to differ in set and temperature from the rest of the ocean east of the longitude of Cape Race, Newfoundland."

Accordingly, we must learn to descend to the plain fact that the Gulf Stream does not, and cannot, convey warm water to the shores of Western Europe, there to modify the climate and give the British Isles the breezes of the "unvexed Bermudas," and Sweden and Norway the warmth of the Carolinas. The meteorologist who is conversant with the fundamental data on which his scientific specialty is based well knows that climatic causation is not a function of ocean currents, but of aerial currents; and easily grasps the fact that the mild oceanic climate of Western Europe is due to the distribution of the permanent aerial circulation over the whole Atlantic basin, of the moderating, mitigating effects of the ocean as a whole. This permanent circulation takes the form of a great cyclone in high latitudes, and of an enormous anti-cyclonic eddy in mid-latitudes; and it is to the mid-Atlantic anti-cyclone that must now be transferred the high climatic credit that has been unduly held by the Gulf Stream for so many years. Indeed, it is well known to the initiated that, allowing this vast aerial eddy to remain as it now is, and the general atmospheric drift in the Northern Hemisphere from west to east to continue the same, the complete disappearance of the Gulf Stream and all the ocean currents in the Atlantic would not have the slightest effect on the weather and climate of Europe, but any shifting of the anti-cyclone would—and every shifting always has had a corresponding effect upon both those conditions. And every considerable displacement of this vast atmospheric whirlpool produces far-reaching climatic phenomena, which are glibly attributed by the believers in meteorological mythology to "shifting of the Gulf Stream"; which very "shifting" itself is due in most instances to the action of the wind-currents of the anti-cyclone!

As those of my readers who are versed in the history of science well know, the "Father of the Gulf Stream" was the father of modern electrical science—the indefatigable journeyman-printer, philosopher, philanthropist, scientist, and statesman, who first drew down the lightning from the clouds along his damped kite-string—Benjamin Franklin. Thoroughly characteristic of that extraordinary man is the fact that in April, 1775, on his return voyage from London to Philadelphia, on which he was obliged to embark for his personal safety, after having received the most ruffianly insults from his aristocratic superiors of the mother country on attempting to negotiate the rights claimed by the New England colonists in their own taxation;—that man, who had then closely approached the limiting age of three-score years and ten, was seen day after day taking the temperature of the air, and then dipping his thermometer in the Atlantic, and scanning the record of the rise

or fall as eagerly as if no other object of earthly interest concerned him at the time. And equally characteristic is the fact that he had with him on board the velvet "Court suit" which he had worn on the special occasion on which he was admitted to the presence of the English Ministers in his function of representative of the New England colonists, and from which he was soon ejected with gross insult as a mere mechanic. That suit was carefully laid aside, and was again assumed—at an interval of eleven years—when the wearer, as Minister-Plenipotentiary of the newly-founded republic of the United States, attended in Paris to witness, in his then *inviolable* capacity, the signature of the same English Ministers to Great Britain's documentary recognition of the independence of the United States! On the voyage referred to, Benjamin Franklin gave the first practical demonstration of the fact that the thermometer could be used to determine the relationship of the voyager to the Gulf Stream, and thereby ascertain the longitude—which was more often guessed at than measured in those days; and which was of comforting importance when a trans-Atlantic excursion occupied a space of six to nine weeks.

Five years before that date Franklin had made, and had engraved for the benefit of navigators, the first chart of the Gulf Stream. But the sturdy British navigators would not look at it. When he arrived at Philadelphia he found that the battle of Lexington had been fought; and he proceeded to suppress his navigation charts as effectively as he could, so that they might not be utilised by the enemy. He had laid down the view that the permanent "trade winds" were the initial cause of the Gulf Stream; and, although partly in error, he was right in believing that the permanent aerial circulation in the North Atlantic is an important factor in determining the aqueous surface drift. His theory as to how winds form ocean currents is fully borne out by modern hydrographic research.

No special further enlightenment on the subject of the Gulf Stream was offered to the scientific world till the appearance of Maury's "Physical Geography of the Sea," in 1855. The theories of this justly famous writer soon attained the position of hydrographic orthodoxy. He made the Gulf Stream an argument for the proof of "design in the physical world." He opposed the idea of Franklin that the trade-winds were at all the cause of the Gulf Stream; maintained that "winds had little to do with aqueous currents," and wrote of the stream itself as "a sheet of warm water, said to be more than three thousand times greater than the Mississippi River," sent "entirely across the Atlantic Ocean." He proceeded to liken its effect on the climate of the British Isles to the heating of a house in winter by means of hot water, and told his readers that "one of the benign offices of the Gulf Stream is to carry heat from the Gulf of Mexico, where otherwise it would become excessive, and to disperse it in regions beyond the Atlantic for the amelioration of the climate of the British Isles and of all Western Europe." Such is the teaching which came to receive the stamp of orthodoxy! Maury knew nothing of the importance of the great anti-cyclonic circulation over the Atlantic Ocean. But its laws are very simple, and are now fully understood by the few. The whole general atmospheric circulation is determined by the expansion of the heated air

in the tropical region, which causes it to ascend and flow north and south to colder climes; and the resulting surface current in the opposite direction, which tends to restore the equilibrium so disturbed. The rotary movement of the subjacent earth from west to east also tends to produce atmospheric currents in the opposite direction. The permanent "trade-winds" represent the "resultant" motion derived from the composition of those two factors. Then the formation of a focus of low barometric pressure causes an inflow from all directions which leads to the production of the aerial whirlpool known as a *cyclone*; while the existence of an area of high pressure causes a spiral outflow towards all points of the circumference involved. The latter condition of the atmosphere is known as an *anti-cyclone*.

Let us now note that in the temperate zones the atmospheric drift is from west to east, which means that all coasts and countries that lie eastward of oceans possess climates ameliorated by oceanic influences, while the eastern parts of large bodies of land have climates affected by the masses of earth surface over which the aerial current has travelled; and we have the key of the whole climatic mystery. The great mid-Atlantic anti-cyclone practically covers the mid-Atlantic basin. Its pressure increases in summer and diminishes in winter. And its necessary movements to north and east determine the happy temperateness—frequently diluted with moisture, we must regretfully add—of the enviable climate of the British Isles.

ON CONTRACTILITY OF THE UNIMPREGNATED UTERUS.

By ALEXANDER DUKE, F.R.C.P.I.,

Late Assistant Physician, Rotunda Hospital, Dublin.

THE late Matthews Duncan says in his "Clinical Lectures" (page 133): "The sticky cervical mucus, as you are all aware, in 999 cases out of 1,000 hangs out of the uterus into the vagina, but I have seen it ascending and filling the cavity of the body of the uterus." This contractile function of the uterus, by drawing the cervical secretions *into* the cavity instead of expelling them, more especially when morbid and containing pus, tends to produce chronic, abnormal conditions of the uterus, and, I strongly suspect, of the Fallopian tubes.

I can quite imagine the uterus of a multiparous woman, more especially when subinvolved and compressed from above by loaded bowels, tight corsets, and perhaps full bladder in addition, acting somewhat like a rubber ball syringe, so that when pressure has been removed, a suction action is set up in the cervix, which draws up the secretions (morbid or otherwise) into the uterine cavity.

This suction action does actually occur during the act of impregnation, assisted by the return of the blood supply from the hyperæmic uterus after the sexual act, and I presume that a similar action may occur from various other causes, nervous or otherwise.

The uterine cavity thus charged over and over again leads me to think that some of the toxic symptoms developed in patients who have been vainly treated for rheumatism, suppressed gout,

&c., have arisen from this cause, combined, perhaps, with the absorption of morbid matter into the blood from fæcal lodgments and constipation in addition, and acting on this I have made inquiry as to uterine symptoms in patients I have been consulted about who suffered from stiff joints, painful at times, with pasty colour of face; and having treated the uterus alone have given relief to all reflex symptoms.

Uterine lameness is sometimes mistaken for rheumatism, and I think it advisable in such cases to make examination, and thus be enabled for *certain* to exclude or include the uterus as even a partial cause of the symptoms complained of. Cases are on record where a uterine stem has been drawn up into the uterus, button and all, while the converse is more commonly the case (expulsion of sea tangle or stem), due (in some cases, at least) to the fact that the tangle, tent or stem were *solid*, and while being introduced allowed of no exit for air or secretion, pushing both upwards, and setting up a contraction soon afterwards, which might act in either direction. For this reason *all stems should be either open from end to end, or grooved at side*, and the same applies to graduated solid "bougies," such as "Hegars," for procuring dilatation. My own impression is, that this contraction of the unimpregnated uterus, by the drawing in of morbid secretion, must eventually imperil the health of the tubes, and when such become patulous at the uterine end I can quite imagine some of the morbid matter with which the uterine cavity has been charged finds its way into the Fallopian tubes, and gives rise to pyosalpinx, &c., &c. So far as my experience goes, I consider that in those cases where secretion from the uterus is observed through the speculum, it is quite as important to secure free exit by drainage-tube or dilatation (or both) as to curette the cavity alone, and allow matters to resume their original condition some months afterwards.

Clinical Records.

DOUBLE PYOSALPINX. (a)

By J. INGLIS PARSONS, M.D., M.R.C.P.

MRS. B., æt. 35, a patient of Dr. Frye, was admitted on November 18th, 1904, complaining of severe pain in the abdomen which had confined her to bed for six weeks. She had been married twelve years, but had had no children or miscarriages. Her menstruation had been regular, but profuse, and accompanied by severe pain for a few days preceding the flow.

Six years ago she had a severe attack of pelvic inflammation with much pain. On examination, a hard, irregular tumour was found on both sides of the uterus. Temperature normal.

November 22nd.—On opening the abdomen the intestines were found adherent to, and almost covered by, two masses, one on each side of the uterus. After separating the intestines further inspection revealed enlarged tubes bound down by extensive adhesions matted to the uterus. These were removed with some difficulty but without rupture.

The patient made an uninterrupted recovery and left hospital three weeks after operation.

A CASE OF RUPTURED OVARIAN CYST. (b)

By GEORGE ELDER, M.D., &c.

MRS. B., æt. 50, was seen in consultation on Thurs-

(a) Specimen shown at the British Gynecological Society, January 12th, 1905.

(b) Notes read before the British Gynecological Society, January 12th, 1905.

day, November 3rd, 1904. Patient had a well-marked ovarian cystoma of the right side, reaching up to the umbilicus, and was advised to have an early operation performed. On the following Monday (November 7th) she came by train some twenty miles to a nursing home, where, in the evening, I saw, but did not examine her, as from her general appearance and absence of complaint, there was no reason to believe that the conditions had changed. Temperature same evening, 97.8°, and pulse 88.

Next morning, on being placed on the operating table, the prominence of the tumour was found to be replaced by a general flattening of the abdomen, and the fluid was diffused. On section, typically viscid, straw-coloured ovarian fluid poured out of the abdominal cavity, and on this being mopped out, the flaccid cyst was felt, resting on the right posterior wall, and was removed. As will be seen in the specimen, there are two small ruptures, and in other places the wall has been much thinned.

Subsequently, on questioning patient, she stated that on the Saturday evening she had some severe abdominal pain and sickness, which kept her in bed all Sunday, but did not seriously upset her general condition nor prevent her taking the railway journey on the Monday. The smallness of the openings would account for the fact that the rupture was not followed by shock, and the slight disturbance to her health was due to the benign character of the fluid. Some sudden distension of the cyst on Saturday evening, due probably to a slight twisting of the pedicle, may have caused the rupture.

My reason for bringing this specimen before the Society is that it not only illustrates one of the rarest and gravest accidents to which ovarian cystomata are liable, but also emphasises the opinion so often insisted upon before the Society, *viz.*, the importance of counselling immediate operation whenever a tumour of this nature is diagnosed.

Transactions of Societies.

BRITISH GYNÆCOLOGICAL SOCIETY.

ANNUAL GENERAL MEETING, JANUARY 12TH, 1905.

PROFESSOR JOHN W. TAYLOR, M.D., F.R.C.S.,
President, in the Chair.

THE Treasurer, Dr. Slimon, having presented his report and balance-sheet and the Editor of the *Journal* of the Society having read his report, and votes of thanks having been unanimously accorded to these officers, and also to the auditors, Dr. C. H. Bennett and Dr. F. A. Purcell, the election of the officers for the ensuing year was proceeded with. A complete list of those elected was published in our last number.

SPECIMENS.

Ruptured Ovarian Cyst.—In the unavoidable absence of the exhibitor, Dr. George Elder, his notes on this specimen were read by the secretary, Dr. AARONS, and will be found under "Clinical Records."

As Dr. Elder was not present the case was not discussed.

Dr. J. INGLIS PARSONS showed a specimen of "Double Pyosalpinx," an account of which will be found under "Clinical Records." He added that the points of interest were the symmetrical enlargement on each side, and the fact that the tubes had been got away without opening them. Those who had operated in such cases would know how difficult it sometimes was to do this when the intestines had been forming a sort of roof to the uterus and tubes, and one had to deal with dense adhesions. He began by separating the adhesions from underneath the back of the uterus, and in time both tubes came up successively, and could then be removed.

Dr. JERVOIS AARONS asked whether a diagnosis of double pyosalpinx had been made before operating on the case, or the blood examined for leucocytosis in view of the possibility of pus being present in the pelvic cavity.

Dr. ROBERT BELL said he had come across many cases of pyosalpinx, and all were bilateral and very easily removed. The specimens of one case he showed to the late Professor Joseph Coats, who, he believed, placed them in the Pathological Museum in the Western Infirmary, Glasgow. He had never met with adhesions in connection with pyosalpinx, nor found difficulty in their removal.

Dr. MACNAUGHTON-JONES said that his experience did not correspond with that of Dr. Bell. He had, again and again, found pyosalpinx with extensive adhesions, nor was their removal always easy. Indeed, some of the most difficult cases in gynecology were those of pyosalpinx, in which the tube was absolutely embedded in adhesions, with a plastic wall completely surrounding it. It was only when one broke through the wall that the pus in the tube was reached. Neither was pyosalpinx necessarily bilateral. Tuberculous pyosalpinx, for instance, frequently affected the tube on one side only. He had exhibited such a specimen before the Society, with a large pus sac, and the patient from whom he removed it had since borne three children.

Dr. HODGSON asked if Dr. Parsons had noticed whether the adhesions in pyosalpinx were much more extensive than in hydrosalpinx.

Dr. PARSONS, in reply, said the temperature in this case was normal while the patient was in hospital, and that was frequently the case. It was a very old case, and he believed the absence of fever was due to the fact that the system had become accustomed to the presence of the toxin. Probably the condition had existed before marriage, and was the cause why the patient had remained sterile for twelve years. He was willing to admit that he did not diagnose pyosalpinx before operation, as it was impossible to form an accurate opinion owing to tenderness on examination. He could not agree with his friend, Dr. Bell, about the absence of adhesions in pyosalpinx, but must concur with Dr. Macnaughton-Jones that such cases were sometimes the worst which gynecologists had to deal with. He would rather do a hysterectomy than operate upon some cases of pyosalpinx. The worst case of the kind he had seen was one in which he assisted one of his juniors at the operation. Both his colleagues were present, and they advised him not to proceed, but sew up the abdomen, which was accordingly done. In another case, a very bad one indeed, it was impossible to remove the sacs without leaving a large raw surface, and the patient died of intestinal obstruction some fourteen days after the operation. His experience was that one met with much worse adhesions in pyosalpinx than in hydrosalpinx; and it was sometimes most difficult to separate the bowel without tearing it, particularly if the case was recent.

The PRESIDENT then delivered his Valedictory Address, which will be found on page 75.

Dr. MACNAUGHTON-JONES said that on several occasions he had had to propose a vote of thanks to a retiring President, but had never done so with so much diffidence as on the present occasion. After the comprehensive summary of interesting and valuable work the President had given, he felt it a responsible task adequately to express the feelings of the Society, or attempt a due appreciation of that work. Professor Taylor had not been surpassed by any of his predecessors in the assiduity with which he had attended the meetings of the Society and directed its proceedings. The address just delivered was most suggestive, and would form one of the most valuable statistical records which had ever appeared in the *Journal*. One fact struck him particularly. During the last four years of his work Professor Taylor had performed thirty-six abdominal and twenty vaginal hysterectomies, fifty-six in all; and during the same period 320 operations of all kinds. As of that number fifty-six were hysterectomies, and among the whole 320 there had been but fourteen deaths, the low rate of mortality was a convincing proof of the merit of Professor Taylor's work. He was also struck by the fact that fifty-seven operations for extra-uterine pregnancy, and various complica-

tions associated with it, had been done, with only two deaths. Furthermore, thirty-eight cholecystotomies, including excisions of the gall-bladder, had been done, with only two deaths, and of the seventy-two vaginal hysterectomies in the table only two were fatal. The Society might congratulate itself on having had as one of its Presidents a man who could bring before it such a perfect record of surgical work. The President had recommended a valuable detail in practice which was too often neglected. Operating surgeons had necessarily to come into contact with septic influences, and make examinations involving septic infection, and he urged that, after contact with such septic conditions, they should always use a powerful antiseptic. This advice should be borne in mind by every operating gynecologist. Professor Taylor was the third President of the Society who had come from the Birmingham School, a school which must always hold a high place in the annals of gynecology. The most original obstetrician which the United Kingdom had produced was Simpson, of Edinburgh, but he would say unhesitatingly that Lawson Tait was the most original gynecologist that England had ever produced. Another familiar name which one was proud to see on the list of Honorary Fellows who had been associated with Birmingham in all minds since their student days was that of Savage. With these illustrious men Professor Taylor was fitly associated. No past President of the Society had more completely gained the esteem of its Fellows than had Professor Taylor; they wished him every success in his practice, long life, and every prosperity, and hoped that he, who had hardly reached the zenith of his fame, would on many future occasions grace their proceedings by his profound learning and vast experience.

Dr. HEYWOOD SMITH seconded the vote of thanks to Professor Taylor for his able address and for his conduct of the business of the Society during the past year. He cordially endorsed all the proposer of the resolution had said in appreciation of what the President had done during his term of office. His conduct, both on entering the Presidential chair and on leaving it, had been characterised by great courage. The Society would never forget the outspoken address with which he inaugurated his term of office, which had been referred to and quoted extensively by lay journals, and had started a discussion which ought to result in an improvement in the social morality and birth-rate in this and other countries. They were also extremely grateful for the address just delivered, and it was a great encouragement to the younger specialists in that branch of surgery that by similar earnestness and attention to details they might hope to emulate the President's success.

The motion having been carried by acclamation,

The PRESIDENT thanked the Fellows very warmly for the kindness which he had received since he was elected President. His year of office had been a very happy one, and he wished the Fellows a very successful and pleasant session under the Presidency of his esteemed successor, Dr. Alexander.

ULSTER MEDICAL SOCIETY.

THE Fourth General Meeting of this Society for the Session was held in the Medical Institute, Belfast, on Thursday evening, January 19th, the President, Dr. WILLIAM CALWELL, in the Chair.

Dr. W. B. MCQUILTY read notes of a case of General Paralysis of the Insane. The patient was a man, æt. 41, in whom the first symptom was transient diplopia fourteen years before, followed by lightning pains in the limbs two years later, which quite passed off. Nothing more was seen till shakiness of the legs began last year. Writing got shaky, he repeated his words, and speech and memory became affected. The special interest of the case was that it was a well-marked example of the spinal form of general paralysis, the earlier symptoms being those of tabes, showing the pathological identity of the two diseases.

PROFESSOR LINDSAY, in discussing the case, admitted the close relationship of the two diseases, but was not

prepared to go as far as Dr. McQuitty in regarding the pathological processes as identical.

Drs. McKisack and Graham also criticised the case.

Mr. A. B. MITCHELL showed a case operated on for Hare-Lip and Cleft Palate, and also an interesting case of Stricture of the Oesophagus. The latter patient had had a Symonds' tube *in situ* for six months, the passage of which was still patent. Mr. Mitchell emphasised the value of this treatment at an early stage, and expressed the opinion that the tube introduced should be of as large a size as possible—No. 18 or 20. Such patients are infinitely better than they would be after gastrostomy, for (1) they can still enjoy the taste of their food; (2) the tube acts as a drain to the oesophagus, and prevents the accumulation of food and secretions above the stricture; and (3) the discomfort of the abdominal opening is avoided.

Dr. H. L. MCKISACK read a short paper on the TREATMENT OF PNEUMONIA BY THE APPLICATION OF ICE EXTERNALLY,

which we shall publish in our next issue.

The paper was discussed by Professor Lindsay, Drs. Dempsey, McQuitty, Shaw, McIlwaine, Mitchell, and the President, and Dr. McKisack replied.

Dr. J. C. RANKIN read a paper on

RÖNTGEN-RAY TREATMENT,

and showed a number of illustrative cases.

Since taking charge of the new electric room at the Royal Victoria Hospital, Dr. Rankin had made 4,473 applications of the X-rays, and had treated 100 patients. Most of these patients had been under treatment of many sorts by many men, often for many years, the electric department being the happy dumping ground for all sorts of obstinate and unsatisfactory cases. The cases treated included 2 acne, 3 alopecia, 13 carcinoma, 10 rodent ulcer, 2 tinea tonsurans, 55 lupus vulgaris, 2 lupus erythematosus, 1 lichen planus, 10 sarcoma, 2 various. At first the time of exposure to the rays was 10 minutes at each sitting, but after a month or so this produced erythema, so the time was reduced to 5 minutes. None of the methods of estimating the strength of dose were quite satisfactory. In the lupus cases, for six months he had used the rays alone, and had got improvement, but after that time he removed the crusts and used an antiseptic dressing as well, and the improvement became much more marked. Not one of the lupus cases became any worse during the course of treatment, and many showed very marked improvement, as was shown by cases and photographs exhibited. Of the rodent ulcer cases some showed excellent results, but it remained to be seen if these were permanent. In the 13 carcinoma cases the results were disappointing, as also in the 10 sarcoma cases. For some time he had substituted radium for the X-rays, but it proved quite useless, and was given up. The paper was criticised by the President, and several other members of the staff of the Royal Victoria Hospital, who expressed their great sense of gratitude to Dr. Rankin for the immense amount of time and trouble he had expended in the establishment of this department, and in the treatment of cases sent to him.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, January 22nd, 1905.

THE COUGH IN PLEURISY.

PLEURISY, so rich in physical signs, is poor in functional troubles. The rigor which marks the *début* is not so intense as that characterising pneumonia; the stitch in the side is not very painful, dyspnoea is frequently wanting; expectoration is absent, and the temperature is usually moderate. It is thus that the pleuritic effusion is, in many cases, discovered by chance; sometimes it is only found *post-mortem*.

There is, however, one symptom which is sufficient to attract the attention of the medical attendant to the pleura—the cough.

The cough is a constant symptom of pleural effusions, be they secondary or primary, sero-fibrinous, hæmorrhagic, or purulent.

It does not exist in dry pleurisy; it appears only when a liquid exudes into the serous membrane. The cough is short and frequent, fatiguing the patient, and is followed by no expectoration. It does not come on without cause, but on the contrary, under well-defined circumstances. Immediately the patient stirs, either to turn in bed or to absorb a liquid, especially if it is cold, he is seized with the cough.

Péter attributes, with reason, this cough to irritation of the pneumogastric filaments. The pleural inflammation is transmitted to the intercostal and phrenic nerves provoking the pain. The liquid, becoming displaced when the patient stirs, strikes the regions above the level of the effusion and irritates the nerve filaments, thus provoking the cough by reflex action.

According to Milliau, every patient taken suddenly with a dry cough by a simple change of position is affected with pleurisy.

The attendant, bearing this precept in mind, can detect pleural effusion in a patient whose general condition is good, and who presents nothing else worthy of drawing attention to the respiratory organs; he can even detect at its *début* liquid in the pleura of a tuberculous patient.

Certain patients suffer also from a cough provoked by sudden changes of position, as those affected with vomica or bronchiectasis, but the cough differs from that of pleurisy by the fact that it is accompanied by expectoration.

The cough of pleurisy can be so harassing and painful that it constitutes the chief symptom of the malady, and necessitates treatment.

In mild cases, it is sufficient to advise absolute rest and silence, and the use of warm drinks. But more frequently active treatment is required and preparations of opium are indicated (laudanum, the black drop, or morphia). Inhalations of ether, frequently renewed by causing the patient to respire a plug of absorbent cotton wool wet with the liquid, is a good adjuvant to the opium preparation.

HÆMOPTYSIS.

Injections of 40 drops of a solution of adrenalin (1—1,000);

or Injections of gelatine, 1½ drachm to 10 ozs.;

or Hydrochlorate of hydrastinin, 2 gr.;
Water, 5 ozs.

A tablespoonful every hour;

or Hydrochlorate of hydrastinin, ½ gr.;
Hydrobromate of quinine, 1 gr.;
Ext. of belladonna, ½ gr.

For one pill, two daily;

or, Chloride of calcium, 1 drachm;
Laudanum, 30 min.;
Syrup of orange, 1 oz.;
Peppermint water, 4 ozs.

A tablespoonful every two hours.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, January 22nd, 1906.

At the Free Society of Surgeons, Hr. Croca reported THREE CASES OF PERFORATION OF THE STOMACH, or of the duodenum, that were presented at the hospital twelve to sixteen hours after the accident, and were all saved by operation. The first was a gun-shot perforation of the stomach; both entrance and exit wounds were united by suture. The second was one of ulcer in the lesser curvature; this was sutured and the abdominal cavity was afterwards thoroughly washed out. In the third case, perforation peritonitis had existed for sixteen hours; the yellow, odourless

contents of the abdominal cavity pointed to the duodenum, where the perforation was, in fact, found. The abdomen was drained in this case, notwithstanding which the symptoms subsided slowly. Pneumonia, which developed in the course of recovery, only retarded it slightly.

Hr. Dirk spoke on

MORPHIA-HYOSCINE NARCOSIS.

After some experiments made for the purpose of feeling the way, they had arrived at a method of giving these anaesthetics in Rotter's department. A solution of 0.001 grm. of hyoscine and 0.002 of morphia were divided equally in two syringes, of which one was given two hours the second one hour before an operation. In twelve patients one syringeful was sufficient; twenty-one required three syringefuls, but the majority (227) were given two in the manner described.

After the first syringeful a tired feeling and a tendency to sleep came on, but the patient woke up on being called to; after the second dose, they were prepared for the operation, were placed on the table, the skin disinfected, &c. The eyes were still open, but the patients were not properly conscious of their situation, and most of them had afterwards no recollection of what had been done. A few whiffs of ether or chloroform were then sufficient to bring about insensibility without any stage of excitement. In twenty-nine cases no further anaesthetic was required. After the injection the pupils were generally somewhat dilated, the pulse was from 70 to 90, the respirations were deep and there was slight cyanosis. The drying-up action of the hyoscine prevented tracheal rattling. Collapse or asphyxia were never seen. In the case of very deep narcosis, Cheyne-Stokes respiration was often observed, or a marked diminution of the frequency of respiration. After the narcosis, a sleep of from five to eight hours followed, out of which the patient awoke feeling well and without any recollection. Retching and vomiting hardly ever occurred, and no pneumonia followed in any case.

Three deaths took place, but all in cases of advanced carcinoma, the patients being respectively 76, 73, and 69 years of age. They were all very decrepit individuals, and they died some hours after the operation, without regaining consciousness. All the other cases bore the injections well. At the same time the rule should be laid down that when pronounced somnolence, pupillary stasis, and cyanosis come on after the first injection, the second should not be given.

A great advantage of this form of narcosis was its humane character, by which all excitement was avoided, its calm course, the nominal employment of the usual anaesthetics, and the fact that when the patients first awakened out of it the first pain from the wound had already passed off, and, lastly, the absence of nausea and vomiting. The drawback was the circumstantiality attending it, and the necessity of watching the patients for several hours afterwards in order to prevent the falling of the jaw and the sinking backward of the tongue.

Hr. J. Israel, on the whole, confirmed the representation of the speaker. He had employed the method in 332 narcoses, and had given at most 0.0004 grm. of hyoscine and 0.002 of morphia, but he acknowledged that it would be better to give it at two intervals. It was some drawback that when a series of operations were to be performed, the exact time for the later ones could not be predicted, so that the hour for the injection could not be fixed. In long operations it was an advantage that a little ether or chloroform be used. In thirty-two cases no ether or chloroform was given. The operations were all serious ones. The psychic factor must not be undervalued; the patient sank quietly off to sleep without being disturbed by any preparations. The extreme difference of action even from the same preparation was a disagreeable feature. This was observable both before and after the operation.

He had had three fatal cases. The first died before the commencement of the operation, but the case was one of anuria of a week's duration, which possibly

explained the fatal result. The other two cases were both young men who for two and three days respectively had been in a state of great excitement after the operation, with very frequent pulse; both died in a state of coma. The autopsy showed in both such a state of fatty degeneration of heart, liver, and kidneys as one only saw in phosphorus poisoning, although in neither case could there be any question of such intoxication. How far the hyoscine caused this could not be determined. The point required further observation.

Hr. Rotter did not think it necessary to wait two hours after the first injection for the operation, the action lasted much longer. The uneven action depended on individuality and not on the drug.

A NEW REMEDY FOR LEUCORRHOEA.

Dr. F. Knapp, of Berlin, strongly recommends the use of this new remedy, which has been introduced under the name of leucrol. It is sold in the form of pastilles, of which five are to be taken in the day, or it may be got in the form of a fluid extract. The feature of the remedy is that no local treatment is required. The leucorrhoea must not be of a gonorrhoeal nature. Two cases of simple colpitis are reported in which the remedy seems to have done good, one being cured after taking 95 pastilles.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, January 22nd, 1905.

OSTEO-MYELITIS TIBIÆ.

At the Gesellschaft Neudorfer showed a patient on whom he had operated for osteo-myelitis of the tibia, where a fistula had existed for a long time. The Röntgen rays showed a sequestrum in the bony canal close above the epiphysial line. The wound was freely opened, sequestrum removed, and granulation, according to Goldmann's operation, induced by a lateral flap with the pedicle above the wound, which rapidly healed, while the newly-denuded surface, by the removal of the flap, was treated according to Thiersch, by transplantation. After firmly binding all together, the wound healed by first intention, with a perfect functional result.

THERAPY OF ARTICULAR TUBERCULOSIS.

This subject has excited a good deal of discussion since Mosetig propounded his method of plumbung. In renewing the discussion, Spitzmüller said that he had had 144 carious cases in the Children's Hospital within the last four years, 22 of which he had treated according to Mosetig's method, with the happiest results. He had not selected the best cases in these experiments, as he had some misgivings in his mind when he commenced that the treatment would not be successful. On this account he selected for the experiments those cases which he had finally set aside for amputation. With this experience he could confidently assure the members that he spoke with no bias or prejudice in the results that he had obtained. The first case he showed was a patient on whom he applied the "iodoform-plombe" as a temporary measure. Another case was a severe form of caries in a child, æt. 11. The left foot was quite beyond recognition as such, penetrated with six fistulae, all ending on bare diseased bone, and emitting a most offensive discharge. The right foot was a mass of fungoid caries in the metatarsus and phalanx of the great toe, necrotic condition of the talus, calcaneum, navicular cuboid, and cuneiform bones, with destructive tuberculous changes in the capsule of the tibia. The whole of the morbid centres were "plombiret," and speedily took on a healthy condition without showing any signs of reaction, which, he contended, was strong proof that the "plombiring" was easily borne by the patient. One hundred days after commencement of this treatment the child was running about without any assistance from crutches or supports. In hospitals poorly endowed, where the necessary material could not be provided, he proposed a rubbing out of the cavities

with a dry, sterilised gauze and then dusting with iodoform.

Lorenz, in supporting Mosevig's treatment said that the "apparatio-therapie" was rapidly falling into disfavour. In coxitis, for example, where the patient has to lie for years and the function of the limb is destroyed before healing is accomplished, nothing is left for him but wearing a support or becoming the slave of the crutch. If we could so combine such a treatment as Mosevig's with the old form of "apparatio-therapie," a great advance would be made in surgery. Unhappily for the treatment the hip-joint has no indication for the use of the "iodoform-plombe."

Bardenheuer gave it as his opinion that the radical cure of hip disease was better treated by extirpating without opening the capsule. In his own private practice, since 1890, he had treated 545 cases of coxitis. Of these 94.8 per cent. recovered without any operative interference, and 63.6 without any pus formation. He thought he was within the mark in affirming that 50 per cent. of all such cases could be healed without expecting any purulent accumulation, and as long as no pus formed he was of opinion that no surgical interference should be undertaken. In his own cases, 31.2 per cent. recovered without any assistance or formation of matter. In old chronic cases where surgery is imperative, he prefers "onkarthrectomu," which really belongs to the category of freely opening up the abscess, removing all necrotic matter, and dressing with tampons to hasten a radical cure. The operation of the future, he thinks, in synovial tuberculosis is the entire extirpation of the capsule or, in other words, arthrectomia synovialis.

Eiselsberg said that Mosevig had obtained a success in this form of treatment which no others could lay claim to, and if his favourable results can be established the treatment would become classic. Tuberculous joints have been troublesome to all our noted surgeons such as Volkmann, Billroth, and König, who were all in favour of removing the tuberculous joint as a fundamental principle of surgery. The new expression of "knochenplombe" was not a happy one, as "plombe" was to stop and leave permanently. The present treatment is to renew the stopping or dressing in the bone frequently and thus induce a healthy surface, while regularly cleaning out the infectious or dangerous matter that tends to spread and finally destroys the joint.

The Operating Theatres.

BURFORD COTTAGE HOSPITAL.

SQUAMOUS EPITHELIOMA OF THE MUCOUS MEMBRANE OF THE LIP.—Mr. LENTHAL CHEATLE was asked to operate on a case of squamous epithelioma of the mucous membrane of the lower lip. The disease lay between the centre of the lip and the angle of the mouth, and was quite superficial; there were no enlarged glands in the submental region or at the angle of the jaw. Mr. Cheatle said he based his operation on the observations he brought forward at the Pathological Society in 1902, when he showed that squamous epithelioma beginning at the angle of the mouth or on the lower or upper lip progressed by involving the region occupied by the orbicularis oris, buccinator, depressor anguli oris, depressor labii inferioris, levator anguli oris, levator labii superioris, and levator labii superioris alaque nasi. The area affected also corresponds to the naso-labial nerve region of Dr. Head. Realising, therefore, what the area of spread would be if left alone, he planned his incisions accordingly. Thus, instead of making his two incisions V-shaped, as in the ordinary way, he made them parallel, and in the direction of the limits of the depressor labii inferioris. These incisions were well wide of the growth and included a segment of the

muscular fibres of the orbicularis oris and nearly the whole of the depressor labii inferioris. From the lower border of the maxilla, the lower ends of these incisions were prolonged in a V shape to a point midway between the hyoid bone and the angle of the jaw; the submental lymphatic glands were removed and the flaps brought together in the usual way. Mr. Cheatle said that if the surgeon separates in his mind the local spread of a cancer in this region, and also in the tongue and around the anus, from the secondary deposit in the lymphatic glands, he will find that the region occupied corresponds to the distribution of the cutaneous muscles; therefore, knowing the regions in which a cancer of these parts spreads, he plans his incisions accordingly. He referred in proof of his words to his articles in the *British Medical Journal*, April 18th and December 12th, 1903. During the spread of a cancer, he said, there can be no doubt that the spread of the primary growth often increases in one direction, and remains limited (possibly only temporarily, but for a considerable time) in other parts. If sections are cut at a part where arrest of growth has occurred, no difference in microscopical appearances can be seen to differentiate it from the spreading edge. There must be, therefore, some other than mere mechanical influence at work to cause even this temporary arrest. In the articles above referred to he stated that this is probably a nerve and trophic influence, a probability supported by the fact that rodent ulcers do not spread in completely denervated areas. Another point he wished to emphasise was, that if a cell or cells separate in cancer and hence become secondary deposits, they are under the trophic influences of the part into which they accidentally trespass. Mr. Cheatle had been referring in his words to the spread of the primary growth.

ROYAL EAR HOSPITAL.

OPERATION FOR RELIEF OF SUPPURATIVE DISEASE OF THE LABYRINTH.—Mr. RICHARD LAKE operated on a man, æt. 49, whose history was as follows: When æt. about 15, he received a kick from a pony on the left side of the face just below the zygomatic ridge; there was no open wound, but he states that some blood came from the mouth or from the ear. Six years after, whilst serving in India, he suddenly had a discharge of blood from the left ear; there was no pain, but he subsequently found his hearing slightly impaired. Two years ago something formed in his left ear accompanied by slight pain, and he states that "something" was removed from the ear by a surgeon. Three months ago he became giddy and suffered from tinnitus and vomiting, and subsequently he began to stumble and fall on his right side. The man was anæsthetised and the head shaved for an area of three inches round the left ear; an incision was made commencing just above the left ear in front and carried along through the edge of the hairy scalp, but curved forward inferiorly to the tip of the mastoid process; the incision was carried down to the bone all except the upper third, where the superficial tissues were alone reflected till the lower edge of the temporal fascia was reached. All tissues below this line and in front of the remainder of the incision, including the periosteum, were pushed forward until the whole of the posterior half of the external bony meatus was exposed, the cartilaginous meatus was separated

from its attachment to bone, exposing a large mass of granulation tissue practically occluding the canal. The membranous meatus was divided longitudinally in the middle line above and below, up to the edge of the concha. A piece of sterilised bandage was now passed through the external meatus and used to keep the ear drawn forwards for the remainder of the operation. The bleeding from all parts of the cut surface was very free, and took some time to get under control. The bone was now removed with a special gouge invented by the operator. In the course of a short time the antrum was reached. The next stage of the operation was the removal of that part of the bone lying between the antrum and the external meatus known as the bridge. The posterior wall of the external meatus was removed from without inwards by the chisel, as much of the external wall of the attic as necessary was next taken away. There was considerable oozing from the surrounding tissues, especially after the tympanum and adjacent parts had been thoroughly curetted. It was now necessary to plug the wound for a short time in order to thoroughly inspect that part of the field of operation where a lesion was expected, that is to say, in some part of the course of the external semi-circular canal. On removing the strip of gauze with which the cavity had been plugged in that situation normally occupied by the bony protuberance of the external semi-circular canal, a small sausage-shaped fleshy growth was found, roughly about $\frac{1}{3}$ inch in breadth and $\frac{3}{8}$ inch long, that occupied both as regards size and shape the protuberance just alluded to. On removing this with a small curette a little orifice was seen entering the bone at either end, these orifices being the continuance of the semi-circular canal. With the electric burr the remainder of the external canal was cut away up to, but without entering, the vestibule. The small flap made by the posterior wall of the meatus was now attached to the back of the posterior auricular flap by two or three sutures. The ear was sponged with Lister's strong solution, and plugged with a strip of antiseptic gauze, the end being brought out through the external meatus, and the wound entirely closed with sutures. Mr. Lake said that it was only of recent years that the enormous importance of suppurative disease of the labyrinth had been recognised at all, and for a much shorter space of time had it been considered possible to afford relief by operation. In the present case the patient's symptoms which pointed directly to labyrinthine disease were vertigo and sickness, and the fact that he fell towards the sound side. Mr. Lake considered this to indicate a destruction of the physiological properties of the canal, whereas irritation caused by suppuration within the canal would be more likely to cause falling towards the side of the lesion. He pointed out that he had removed the remainder of the semi-circular canal in order to get into healthy tissue, but as there was no sign of pus within the canal he did not enter the vestibule, for he believed that there was no necessity to enter the vestibule unless it was already the seat of disease. He said that some surgeons advocated entering the vestibule in cases such as this, but he thought it was very probable that in the cases in which prolonged giddiness had followed similar operations this was due to this casual treatment of the vestibule. His own view as to the correct treatment of such cases as the one just operated upon was, that it would be better to leave untouched the remains of the bony canal and to content oneself with a thorough removal of all granu-

lation tissue, together with a careful sterilisation of the cavity by means of Lister's strong solution, than to cut away parts of the labyrinth not yet physiologically defunct, unless the operator was prepared to remove the whole of the front wall of the vestibule in order to do away with the functions of the posterior half of the labyrinth. The importance of conservative surgery in operations performed for suppurative disease of the middle ear was not, he considered, sufficiently understood, and under ordinary conditions the removal of parts physiologically sound was bad surgery. It was more important to conduct the operation in such a way as to preserve all the parts of the internal ear which were not destroyed by disease. Finally, in such cases, he said, skin-grafting of the cavity was to be advocated on account of the great depth of the wound.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JANUARY 25, 1905.

THE HOSPITAL FUNDS AND THE WESTERN SKIN HOSPITAL.

IN his last issue the editor of the *Hospital* maintains a discreet silence when pressed with various home questions as to the Funds and the sale of the site of the Royal Orthopædic Hospital. We regret this exceedingly, as he was practically the only mouthpiece of the Funds that has hitherto come in evidence with regard to our present series of articles. We had hoped that Sir Henry Burdett would have given us the views of the Hospital Sunday and King Edward's Funds with regard to the exclusion of Scotch diplomates from nine-tenths of the London hospitals. The Funds should certainly have a definitely declared policy upon this important point, for when they approved the amalgamation of the Royal with the National Orthopædic Hospital the exclusion of Scotch diplomates (waived for a limited period in favour of one particular individual) was made an essential condition by the National Orthopædic authorities. What has Mr. Martin to say to that? As chairman of the National Orthopædic Hospital, he would be fully informed upon the point, and as honorary secretary of the Hospital Sunday Fund he would have every opportunity of acquiring and of imparting full information to his fellow councillors. The presence of Mr. Martin in this dual capacity we consider renders the necessity of a

public investigation of the circumstances attending the sale of the Royal Orthopædic Hospital more imperative than ever. Mr. Martin would naturally welcome the £40,000 which the Royal Orthopædic would bring to the funds of the Royal National. The committee of the Royal Orthopædic would eagerly grasp at amalgamation as a means of evading unpleasant criticism, and to cloak the financial disaster consequent on the senseless sale of their magnificent freehold site in Oxford Street. As an *ex officio* member of the Distribution Committee of the Sunday Fund, Mr. Martin's presence may or may not explain to some extent the policy of that Fund in regard to the Royal Orthopædic Hospital. At the least, we regard his dual capacity as unfortunate. How has Mr. Martin's influence been used with regard to the City Orthopædic, which so far has maintained a sturdy independence of the Funds and resolved to avoid amalgamation? Doubtless his hospital, the National, would welcome the influx of another £4,000, even at the expense of one or two Scotch graduates. We will for the time being leave this question and turn to a hospital that has been persistently refused awards by the Hospital Sunday and the King Edward's Funds. We refer to the Western Skin Hospital, of Great Portland Street, London. This institution is one of the oldest special hospitals in the world. Fifty years ago it was founded as a pioneer in the study of diseases of the skin, long before any special departments were dreamt of in the large general hospitals. During the half-century of its existence this small hospital has carried on its work with humble and unassuming earnestness. Its income at the present moment does not exceed £400 per annum, and the absolute economy of its management may be gauged from the fact that the small sum mentioned provides for an average of 8,000 to 9,000 attendances of patients. To a long career and to unceasing economy of management may be added an honourable history. During the fifty years of its existence no breath of scandal has ever been connected with the hospital. Another skin hospital, which has been the object of repeated and unanswered public charges of the gravest nature, has received, and still receives, substantial grants from the Sunday and the King Edward's Funds. Why is the Western Skin Hospital sent empty away? Years ago its application for a grant from the Sunday Fund was met with a request to submit accounts on a different plan. That was done, and next year a member of the medical staff appeared before the Distribution Committee. He was told to apply again next year, and did so, but without the desired result. A year or two later another member of the medical staff appeared before the same committee at the Mansion House, and was advised by the chairman to attach himself to a better hospital. The details of these visits are doubtless recorded in the minute-books of the Sunday Fund Distribution Committee. The delegate who met with this rebuff reported to the Committee of the Western Skin Hospital, which, as

a self-respecting body, has naturally since declined to apply further to the Sunday Fund. The absolute honour, financial and otherwise, that controls the administration of the hospital is testified by the fact that for a great many years the treasurer has been Dr. Prosser James, formerly lecturer at the London Hospital Medical School. On his retiring a year ago he was succeeded by the Hon. Harry Lawson, M.P. If the Hospital Sunday and King Edward's Funds persist in casting so unmerited a slur upon the Western Skin Hospital, we think that the public have a right to ask on what grounds a grant is refused to that institution. If the two Funds mentioned are right in their action, then the Metropolitan Saturday Fund is wrong, for the latter has for years past made an annual award to the Western Skin Hospital. This recognition by the Saturday Fund is significant, as by its system of representatives from the class benefited by hospitals we have direct approval by those who have had an opportunity of testing the work of the particular hospital in question. The plain and definite question we put to the Sunday and the King Edward's Funds is, "Why do you refuse a grant to a small, struggling special hospital which presents a long and honourable record of charitable and scientific work, which is managed with absolute and unflinching economy, which is associated with honourable names, and against which the voice of calumny has never been raised?" Perhaps Sir Henry Burdett will answer on behalf of the Hospital Sunday and the King Edward's Funds. It seems hardly likely that the public which finds the money for the Funds would willingly lose the aid of a charity that does them so much service year by year. By this autocratic action of the Funds the Western Skin Hospital is condemned, as it were, by an irresponsible star-chamber system, without just trial. This, we feel sure, has only to be brought to the notice of King Edward to be promptly remedied.

THE PROBLEM OF THE ALIEN.

THE alien problem is a ripe theme for scientific as well as political discussion. Clearly it is a subject pregnant with vast medico-sociological factors which physicians and humanitarians generally should face with serious and analytical gaze. Our country has long been the refuge for outcasts from other countries. It may be freely admitted that no little benefit has accrued to us as a nation from the infusion of healthy, foreign blood in past years. Many of these settlers among us have been skilled of hand and active of brain, with vigorous bodies and well-trained minds, and their incoming has been of incalculable advantage. But at the present time, as every observant man well knows, our shores are being invaded by hordes of inefficients, many of whom are decadents in mind and body, deteriorates in morals, creatures that harass and hinder the evolution of the race. These degenerates through our out-patient departments, they gain entrance

to our hospitals, they grasp the charities established by our fathers, and we quietly nurse those who, biologically viewed, are literally drinking our life blood. It is quite unnecessary to furnish facts and figures to the medical mind. Every member of our London hospital staffs knows the appalling extent to which the burden of the alien is adding to the difficulties of the British benevolent. It is not for us either to suggest or advocate any particular form of legislative or other redress. We would, however, draw attention to one important point, a view ably brought out by Dr. Hyslop recently, in a discussion held by the Society for the Study of Inebriety, on "Alcohol in its Relation to Racial Degeneration." Dr. Hyslop clearly shows, and other observers have drawn attention to the same fact, that the British character is undergoing a remarkable psychological change, an alteration which in many of its aspects is of most serious import. With the urbanisation of the people and the spread of alcoholism and other habits detrimental to mental efficiency and physical progress, there is creeping over the country a hebetude and lassitude which impair resisting powers, and inhibit the natural protective mechanism. And there is some reason to believe that this parasitic spread of alienism is dependent in great measure on the lowered efficiency of our people, the diminished resisting power of our nation. Among a virile people the inefficient alien can gain no foothold. If the great hypothesis of Darwin contains anything of truth it is applicable in the present case. The survival of the fittest is still the demand of Nature, and this fitness is dependent upon powers of adaptation to environment. The alien, even when diseased and decadent, usually possesses immense powers of vitality. As every London physician well knows, the alien Jew of the East End, in spite of absence of nutritious food, with lack of almost every hygienic necessity, and even when heavily weighted by disease, often maintains himself in active competition with our own countrymen. The sad fact seems overwhelmingly true that among large numbers of our people there exist psycho-physiological states which readily permit of the encroachment of the alien, and oftentimes give to him a conspicuous advantage in the struggle for existence. The alien problem may be political, but it is none the less essentially biological.

THE DEWSBURY EPIDEMIC.

VACCINATIONISTS, anti-vaccinationists, advocates of the "Leicester method," sanitarians, and everybody who has regard for the decencies of life will do well to read the report made by Dr. S. W. Wheaton to the Local Government Board on the outbreak of small-pox at Dewsbury. This report discloses a state of things prevailing a few months ago in an English town, administered by self-elected representatives, that would be difficult to match with anything that occurred

in the chaos of the South African War medical arrangements. For stupidity, obstinacy, want of foresight, and super-abundance of red tape, we think that the story disclosed by Dr. Wheaton would not be easy to beat. Dewsbury for a long time past has been one of the anti-vaccinationist towns; not only have the Guardians been passive resistors to the Vaccination Acts, but at times they have been active resistors into the bargain, and vaccination had, in consequence, fallen to a low ebb at the beginning of last year. Now we should have thought that it behoved all honest anti-vaccinationists, if they determined on a policy of neglecting vaccination, to re-double their efforts to provide as complete machinery as possible for dealing with small-pox when cases did occur. This is the logical corollary to the anti-vaccination conviction. So long as small-pox is liable to break out, it will be necessary to fight it by vaccination or sanitary administration, or both. This point is thoroughly grasped by the authorities at Leicester—a town probably the worst vaccinated in the Kingdom—and so complete are their arrangements, and so vigorous their administration, that the success they have attained in dealing with outbursts of small-pox has come to be used as an argument in favour of the "Leicester method," as opposed to vaccination. It may safely be said that there was not much suspicion of the Leicester or any other method about the proceedings at Dewsbury. Sheer neglect of obvious public duty alone could have brought about the discreditable muddle which Dr. Wheaton temperately but ruthlessly discloses to the Local Government Board and to the public. Small-pox having shown itself last spring in the Dewsbury district, the Local Government Board wrote to the Guardians in April, asking what steps they proposed to take to secure vaccination and re-vaccination of the population, only, however, to receive in reply a communication from those wiseacres saying that they did not think it expedient or necessary to take any steps. As the outbreak continued, the Local Government Board wrote again in September, urging that vaccination stations should be opened, and being evidently dissatisfied with the information that came to them, very properly sent Dr. Wheaton down to investigate and report on the condition of affairs. We can best give an idea of what he found by quoting, as far as possible, his own words. The town small-pox hospital was situated in a corner of the cemetery; it was surrounded on three sides by an open rail fence, the side facing the cemetery being entirely unguarded. "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." Nor can much blame be attributed to the patient. "The hospital consisted in 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. . . A foetid smell was noticeable outside the hospital, and heaps of refuse and partially consumed food lay around it, on which starlings and other birds were feeding." "On entering the building the foetor was extreme; the wards were much overcrowded, and were pervaded by flies, which arose in swarms from the patients when disturbed. The interior of the wards were very dirty, particularly the floors of the water-closets, which were of wood boarding." Cases from the surrounding districts were being admitted in the town hospital at this time, but owing to a fire destroying some extra buildings in course of erection, the Council refused to admit any but their own cases, and the joint Hospital Board for the outlying districts having neglected to provide either a site or a hospital, although it had been in existence for eleven years, small-pox patients in those districts were left at their own homes. In the Ravensthorpe Urban District, on his second visit, Dr. Wheaton found fifty-two cases thus retained, the necessaries of life being carried to them by the Council's servants, many of whom had not been re-vaccinated. Needless to say, several of them were infected in turn. "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 relatives in the acute stage of the disease. . . . As a rule, the homes of Ravensthorpe are well furnished, and the people are well off in the material sense; but few dwellings have more than two bedrooms, and hence the conditions arising where several cases of small-pox had occurred in the same household were often such as would hardly be credited in a civilised country. . . . 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." We have not space to quote further, but would only remind our readers that we are not referring to an epidemic of plague in the Middle Ages, but to an outbreak of small-pox in a prosperous English town, in the year 1904. Dewsbury and its surrounding districts would seem to be egregious relics of barbarism dying hard before the advance of modern civilisation.

Notes on Current Topics.

Death Certification.

AN incident which is being widely canvassed by certain sections of the press calls attention once more to the unsatisfactory conditions of death certification in this country. A woman, subject to cataleptic seizures, was taken ill with some complaint, and after a time, during which she appears to have been medically attended, her death was reported to the doctor, who thereupon granted the usual certificate. An undertaker was called in, and he found the

body, stripped and lying in a cold room, covered only by a sheet. He proceeded to take measurements in the ordinary way, when he noticed some movement of the eyelids, and this being repeated, he proceeded to attempt to restore animation by friction and warmth. His efforts were soon successful, and the woman regained consciousness and movement, though her condition was one of considerable danger for some time owing to her exposure and mental distress. Before the news of her revival was communicated to him, the doctor had heard that the woman had been subjected to an assault by a thief not long before her death, and he promptly telephoned to the registrar to cancel the certificate till he had communicated with the coroner. While we are unable to believe that the woman would have been buried alive under any circumstances, the story throws into strong relief the necessity for a system of inspection and certification very different from that which holds at present. The fact that a death certificate is demanded by the State from medical attendants, and that the latter are bound to furnish it without fee or reward, and that they may rid themselves of all responsibility in the matter by inserting "as I am informed," is creditable to no civilised State that sets a value on the lives of its citizens and on the prevention of crime. A death-certificate should be a confidential document supplied to the registrar by the doctor in attendance as the result of a special visit made after death, and should carry with it an adequate fee for the service. Moreover, no death should be registered without such a certificate or a coroner's order. The continued acceptance by registrars of the statements of unskilled persons as to the death of relatives is little less than scandalous.

Syphilis in General Practice.

THE danger of contracting some specific disease is a risk run by the medical practitioner in whatever class of practice he or she may be engaged. In the great majority of instances the physician is fully aware of the danger, and active means are employed to prevent such accidents. It is in doubtful or latent cases of infectious disease that the greatest danger exists of inoculating others, and the question also arises of the influence exerted by inanimate objects, including food, in the spread of infection. The diagnosis of venereal affections and of syphilis in particular is not always a simple matter, for it is well known that the primary lesion may be apparently absent, or so insignificant as to escape ordinary observation. The case is, therefore, apt to be dismissed lightly only to return after a couple of months covered with a profuse secondary eruption. More puzzling still are the anomalous and transient cutaneous rashes occurring in the early secondary period, particularly in women. According to Dr. Horace Wilson (a) the infectivity of syphilis is not

(a) *Med. Times and Hosp. Gazette*, December 31st, 1904.

emphasised sufficiently to patients. He has tabulated a series of twenty cases occurring in his own private practice in which he traced infection, either by the usual method or through the handling of food-stuffs or utensils. It is not pleasant to contemplate the fact that two milkmen "went through the whole disease while doing their ordinary duties of lading and carrying round milk," or that others engaged in such occupations as stewardess, barmaid, grocer's boy, and waiter were suffering from a loathsome complaint the infectious nature of which was, perhaps, scarcely or not at all realised by the respective victims. Dr. Wilson pleads for the better education of students in syphilology, whereby accuracy of diagnosis will be the more ensured and the spread of the disease to some extent checked. Notification does not, at the present time, appear to be of much practical utility.

The Electro-Magnet in Eye Work.

OUR contemporary, the *Ophthalmoscope*, bids fair to touch high-water mark in the annals of special medical journalism. It announces that its next issue will contain three important original communications upon the electro-magnet in ophthalmic surgery by three of the greatest exponents of that invaluable means of removing splinters of metal from the eye-ball, namely, Professors Hirschberg, Haab and Snell. Professor Haab's article will be of particular interest, since he describes how the "giant magnet" should be employed. There are reasons for believing that some of the failures with this instrument are to be ascribed to ignorance of how to use it. Both Professors Hirschberg and Snell favour the employment of small instruments, the so-called hand magnets, worked either from the street main, when that source of energy is available, or otherwise from batteries or accumulators. That a young journal like the *Ophthalmoscope* should be able to arrange a symposium of this sort shows that its management is marked by well-directed purpose and energy. Speaking generally, we should imagine that enterprise of this quality may still find hidden treasures in the field of medical journalism.

Inquests in South-West London.

THE situation in which the medical men in South-West London find themselves with regard to Mr. Troutbeck, to say the least of it, continues strained. We notice that Dr. Freyberger is still being called in as an "expert" and that his testimony is frequently in conflict with that of the local doctor. At an inquest held at Lambeth last week on a goods-checker on the London and South-Western Railway, the medical man in attendance ascribed death to a carbuncle in the neck, which led to pneumonia and cardiac failure. Dr. Freyberger, who is still referred to in the daily press as the London County Council Pathologist, propounded the theory that the carbuncle was due to a scratch on the finger, and consequently the unedifying spectacle was presented

of the views of two medical men on an expert point being submitted to the arbitration of a coroner's jury. In the absence of full information, it is, of course, impossible to form a definite opinion as to which of the two views was the correct one, but it seems that this matter was eminently one for friendly consultation and agreement before the inquest, so that a clear and definite view might have been laid before the jury. In any case, we presume Dr. Freyberger did not deny that the carbuncle on the neck was the mediate cause of death. With an ingenuity worthy of a hair-splitting "expert," however, he appears to have preferred asserting his superior acumen by going back to the original scratch as the cause of death. His position in this case demonstrates to a nicety the average value of the expert pathologist's opinion compared with that of a common-sense experienced general practitioner. When, however, amicable relations are rendered difficult by such incidents as have taken place in the past, one cannot expect the wheels of the coroner's court to run smoothly, and it is obvious to the meaneast intelligence that, in consequence, the public good is not likely to be subserved in the way it should be.

Dried Milk.

UNTIL the vexed question of how cheap, fresh, trustworthy milk is to be supplied to dwellers in towns is finally settled, every means, however artificial, by which such milk can be obtained is worthy of attention. Although it would hardly be seriously proposed to feed the nation as a whole on dried milk, yet, in the absence of any guarantee with the dairyman's product, it seems likely that a sphere may be open to milk so treated which is at present occupied by less desirable substitutes. In the November and January numbers of *Public Health*, communications on the subject appear, and in the latter issue Dr. Priestley gives an encouraging account of experiments of his own and those of other people on the changes that take place in milk that is artificially dried. The method employed for the preparation of the milk is as follows:—Two upright cylinders heated to between 220° and 230° F. are arranged parallel to one another, and milk is poured into a narrow interval between them. The water in the milk is instantly evaporated, and the dried products are stripped off the cylinders with a knife, and made to pass through a sieve which ensures only a fine powder resulting. The whole process only takes half a minute. The powder thus obtained can be instantly converted into milk by the addition of hot water, and the fluid so formed is not only sterile, but indistinguishable from ordinary milk in taste, smell, and appearance. The only appreciable changes are a slight lowering of butter-fat, as tested by chemical methods, and a certain change in the casein which prevents it forming large clots when brought into contact with gastric juice. After all, however, the truest guarantee of the efficiency of a food is its power

to nourish, and Dr. Priestley quotes the experience of Dr. Magill, of New York, who fed 850 children on dried milk during four months last summer, Dr. Beaumont, of East Ham, and Dr. Dunn, of the Crèche, at Ilford, to show that the milk is well absorbed and appreciated by the tissues. The bacteriological purity of the milk is also shown by the fact that no cases of diarrhoea occurred in any of the children so fed. It would thus appear that milk prepared from dried residues is preferable for children to the sweetened and preserved milks that have been so popular among the poorer classes.

Small-pox Research in London.

OUR readers will remember that some time ago an application was made to the Metropolitan Asylums Board by the superintendent of their small-pox hospital at Joyce Green, Dr. Ricketts, to sanction certain experiments on animals. These experiments were necessary if advantage was to be taken of the wealth of clinical material in the hospital for the purpose of pathological and bacteriological research. One would naturally expect that such an application would have been cordially granted, more especially as there would be no expense attached, and the experiments and their conditions would be subject to Home Office regulations. Unfortunately, the antivivisectionists saw their opportunity, and offered violent opposition both on and off the Board. Every attempt was made to foil Dr. Ricketts' scientific curiosity, but we are glad to learn that after many months' debate the Board has at length decided in his favour. It is interesting to reflect that this Board spends the greater part of a million of money every year in its fight against infectious diseases, but it at the same time hesitates, on sentimental grounds, to permit those researches which may render such expenditure unnecessary.

Water-Divining.

IT may happen, and it is a consummation devoutly to be wished for, that the spread of scientific education will gradually permeate the minds of people with a beneficent desire for evidence before accepting for gospel the specious pretensions of persons who are interested in deceiving them. One of the hardest of beliefs is that in the water-diviner, the wise man of the country who is able to tell, by the oscillations of his rod, where water lies beneath the surface of the earth. From time to time one sees instances of local authorities employing these charlatans, and if by any chance water is hit upon as the result of their guesses, the result is trumpeted forth as an instance of their sagacity. Of the numerous failures that take place the employers are discreetly silent, and it is comforting to know that the Local Government Board auditors invariably disallow the fees paid to these charlatans. A sound knowledge of geology is a necessary antecedent to any certain prediction of the presence of water in any particular spot below the ground, and the fact of the existence of water is of such importance to public health

authorities that considerable expense in the matter of expert fees is justifiable under this head. In the columns of the *Times* we notice a correspondence has been going on from which it is evident that the belief in impostors who pretend to be able to find water dries as hard as the belief in modern miracles wrought by patent medicines and quack treatments. A strong, clear contribution, which emanated from the pen of Dr. Thresh, Medical Officer to the Essex County Council, ought to settle the controversy out of hand. Dr. Thresh says that he has seen large sums of money wasted by landowners in sinking wells in positions where any hydrologist could have said at once that water was unobtainable, and that as for the V-shaped twig, any person with a little practice can make it perform most mysterious gyrations, without any perceptible movement of the muscles. When movements of the twig actually do occur, Dr. Thresh attributes the phenomenon either to wilful trickery or "unconscious cerebration." It is reassuring to be reminded that medical practice is not the only sphere where the brazen-tongued charlatan is able to compete successfully with the men who have made a life-study of the principles of their profession, but we have some reason to hope that increase of accuracy of true knowledge may soon render these pretenders as much of an anachronism as muzzle-loading guns or wooden battleships.

A Case of Glanders.

IN the field of public health there are few subjects more interesting than that of the passage of diseases from animals to man, just as in the field of bacteriology the comparative susceptibility of different races of animals to different infections is a question of alluring interest. It is, therefore, of importance from every point of view that those rare cases of infection of man by such diseases as are more common among the lower animals should be recognised, the source of contagion traced, and, where possible, the pathology investigated. In a case of glanders reported by Dr. Stephenson, of Dunmore East, (a) both the clinical condition and the mode of infection are interesting. The first lesion was in the shape of hard swellings on the roof of the mouth, followed a few days later by swellings under the jaw. The disease through its whole course centred about the mouth and nose, and resembled closely the condition commonly observed in the horse; subcutaneous nodules appeared on the chest, abdomen, back and face. The entire illness lasted one month, terminating fatally, but, as far as could be made out, the lungs were not affected, and the temperature never rose above 101° F. The course of infection was at first difficult of discovery, but on investigation it was found that a horse on the farm where the patient lived had been treated two years previously for a disease which was undoubtedly glanders. The horse had recovered, and been sold, but some of the manure

(a) *Dub. Journ. of Med. Sciences*, January, 1905.

from his stable lay in a pit under fresher manure for the two years. It had first been disturbed a few days before the patient's illness occurred, and he, while working at its removal, was in the habit of picking his teeth with his nail. There is little doubt that he carried some of the infection from the old manure heap to his mouth during this process.

Dropsy and Salt.

THE studies of M. Widal into the relation that exists between the administration of salt and the occurrence of renal dropsy are deserving of attention, and should furnish a new line of guidance in the treatment of Bright's disease. In several cases of nephritis of different types M. Widal has noticed that, by increasing the quantity of salt given to the patient, œdema was produced or increased, while when salt was withheld œdema, dyspnoea and other symptoms rapidly disappeared. The explanation offered for this curious phenomenon is simple. In certain cases of Bright's disease the kidneys are unable to excrete the normal quantity of sodium chloride, and it is deposited in the tissues. Collecting in this position, it attracts water to itself, and dropsy results. In cases of renal dropsy then, by diminishing the supply of salt in the food, we are able gradually to reduce the quantity in the body below the level at which the kidneys are able to cope with it, and thereby to restore the saline equilibrium. Of course, the abstinence from salt is never to be absolute, but by forbidding the use of extra salt in cooking and as a condiment, one can often restore the proper equilibrium, and thereby put an end to the dangerous hydration which gives rise to œdema.

A Novel Experience.

A STORY as remarkable as any we have read—so remarkable, indeed, that we would be loath to give it credence were it not vouched for by two unimpeached scientific witnesses—is told by Dr. Sidis, of Harvard, and Dr. Goodhart, of Yale, in their book entitled "Multiple Personality," published last week. The story is that of a Mr. Hanna, an able and cultured Baptist minister of Connecticut, who had the misfortune some eight years ago to be thrown from a trap on to his head. He became unconscious and remained so for two hours, when he gradually came round and violently assaulted his attendants without apparent cause. When he had been calmed down, although apparently conscious, he could not talk, and his movements were purposeless and evidently not co-ordinated by intelligence. This condition lasted a long time, and then very gradually his powers one by one reasserted themselves. Mr. Hanna's sensations whilst in this condition were very remarkable. When he came round after the accident all memory of the past was blotted out, and he was conscious of nothing except of his own existence. He, indeed, started the whole of his conscious existence *de novo*, and had to go through all the stages of learning again as he did in infancy. Thus, on

waking first, he saw all objects around him in the same plane, the power of stereoscopic vision having gone. He would stretch out his hands to grasp trees on the opposite side of the road, and was quite nonplussed at being unable to discover behind the looking-glass the person whose face he had seen mirrored in the front. The arts of walking and talking he had to learn afresh, but they were more rapidly acquired than in childhood. Many of his mistakes were ridiculously naïve; for instance, he was astonished to see how a cart could be separated from a horse, and the phenomenon of a rider dismounting from a bicycle struck him as a kind of self-mutilation. Mr. Hanna not only lost all knowledge of persons, but all affection for his family and *fiancée*, and, still more remarkable perhaps, his knowledge of the relations of the sexes and the fact of death terminating life. Finally, however, full adult consciousness returned, and all the memories of the past were released, and blended in his new life. Fortunately he was then able to record all his extraordinary impressions of what had taken place since the accident.

Proposed Extension of the Rotunda Hospital, Dublin.

THE many medical men who at some period of their career have received clinical instruction in the wards of the Rotunda Hospital will doubtless learn with interest that the Board of the hospital has determined to add another wing to the existing building. The Rotunda Hospital possesses one of the most interesting histories and buildings of modern hospitals. Its foundation was foreshadowed by the opening of a house for the reception of poor lying-in women in Great George's Street, by Dr. Bartholomew Moss, the first Master of the hospital. Subsequently, the main block of the present building was erected, and was incorporated by Royal Charter. It received its first patient in 1757. Its generous founder expended the best years of his life, and almost his entire fortune in its foundation and died penniless. In 1771, a room and apparatus was ordered to be fitted up for lectures in midwifery and disorders incident to women and children. In 1785 the new Assembly Rooms were commenced. It was expected that they would prove a valuable source of income to the hospital, and this expectation was fulfilled. In 1813 the ground and premises "lying west of the parent hospital" were purchased from the trustees of the Richmond Asylum for the Blind, and out of the building was made an auxiliary hospital. This building was subsequently devoted entirely to beds for gynaecological diseases, in which capacity it was used until the opening of the new auxiliary hospital in 1896. It was then converted into a residency for students, for which purpose it is at present used. In 1890 the Governors decided to commence the erection of a new building to take the place of the old auxiliary hospital, which from its construction was unsuited for that purpose, and to provide much-needed accommodation for nurses.

This building was opened during the last year of the Mastership of Dr. W. J. Smyly, to whose exertions its erection was largely due. The additional building which has been decided upon is rendered necessary for the accommodation of maternity patients, who now number close on two thousand in the year. It will also contain additional accommodation for nurses and students, thereby rendering it possible to increase the numbers of both.

Arsenic in Urine.

THE presence of arsenic in the urine after administration of the drug is recognised as of constant occurrence, as it is by the kidneys that the greater part of it is excreted. It is not so generally known, however, that arsenic may be present in recognisable quantity in presumably healthy urine. That it may be regarded as a normal constituent of the urine of a large proportion of the population is nevertheless made clear by the investigations carried out by Mr. William Thomson. (a) He examined the urine of a large number of residents in the city of Manchester, and found arsenic in recognisable quantity present in every case. As many of the persons concerned were total abstainers, and there was apparently no pollution of food, the only source of the arsenic seemed to be the air. Further differential examination confirmed this hypothesis. A series of specimens of urine obtained from residents in various manufacturing towns was examined, and arsenic was found to be constantly present. On the other hand the urine of people living in the country was all but free of arsenic, and that of residents in peat-burning districts was entirely so. Examination of soot from a domestic chimney where coal was burnt showed large quantities of arsenic, and dust on the shelf of a shop in Leeds contained as much as a third of a grain of arsenic per pound. It is important to bear these facts in mind, as otherwise the unexpected discovery of arsenic in urinary analyses might lead to wrong conclusions.

Detention of Patients.

OWING to the publicity offered by a coroner's inquest, an untoward incident which occurred recently at St. Mary's Hospital has given rise to a good deal of comment. A man stated to have been suffering from acute bronchitis was admitted on the 6th of this month, and after four days' treatment he got up and insisted on dressing. The house-physician and resident medical officer did their best to persuade him to get back into bed, but the man was obdurate, and claimed the right to leave the institution. This he was allowed to do, and after wandering about the streets for some three hours, he found his way to the police station. The inspector rapidly came to the conclusion that the man was not in his right mind, and had him conveyed to Paddington Infirmary under an urgency Lunacy Act form. Three days afterwards the man died of pneu-

monia. Dr. Danford Thomas, who conducted the inquest, commented on the laxity of the administration of a hospital that would allow a delirious patient to get up, leave the institution, and wander at his own will about the streets, and intimated that he would write to the hospital authorities on the subject. It is always easy to be wise after the event, and we know well what would be said if a patient who was *compos mentis* were detained by force in a voluntary hospital when he was determined to leave if possible. But there must always be a certain discretionary power left with medical men in charge of patients, and though they have no statutory right to detain any patient not under the Lunacy Act, still they have the right of all good citizens to prevent another doing himself damage. In the present case the doctors in question did not consider the man mentally afflicted to a sufficient degree to warrant the use of force, but surely they could have withheld his clothes till his friends had been communicated with, and no one would have blamed them for not permitting a man in his night attire to go out into the streets. As events proved, the man's restlessness and obstinacy were part of his illness, and we should have thought this would have been the dominant idea in the minds of medical men experienced in acute febrile illnesses. In this case an error of judgment has been committed, and it is to be hoped that the Hospital authorities will gather wisdom from experience, and call in an experienced member of the honorary medical staff to advise in future cases of difficulty.

The "Live Burial" Scare.

THAT popular fiction die hard is a well-known maxim. Of all such myths that of premature burial is one of the most cruel, while at the same time it rests on no established foundation of ascertained fact. Some years ago the whole question was investigated and discussed by a scientific medical man in a little book published by Bailliere, of London, under the title "Premature Burial, Fact or Fiction?" He came to the conclusion that while the literature and hearsay evidence was enormous, yet on the other hand no single instance of incontrovertible proof of live burial existed. At the same time, he did not deny that under circumstances of hasty burial, as in time of cholera or on the battlefield a body might be buried while still alive. That the fact of death could not be ascertained by the careful examination of a skilled medical man is beyond belief. In the absence of scientific evidence of live burial, the birth of a society, engineered by medical men, to prevent such an occurrence, becomes a laughing-stock for all wise men. The faculty of correct observation and logical reasoning, however, is not always guaranteed by the possession of a medical degree or diploma. In the recent case where a woman was resuscitated after having been laid out for dead, it was shown that the certificate of death had been filled up by the medical attendant on the strength of the friends

(a) *Medical Chronicle*, December, 1904.

report. The fact that a person was not buried alive scarcely warrants the wholesale revival of a mischievous and foolish scare.

Medical Editors in Glass Houses.

AN article recently published in the columns of a medical contemporary severely criticised medical writers who noticed proprietary drugs or medicinal preparations. Now there is no doubt that many such articles are widely patronised by medical men throughout the United Kingdom. Secondly, the leading medical journals freely insert the advertisements of such preparations, provided that the formula is not kept a secret. That being so, it is not easy to see on what grounds a medical editor can cry "maranatha" to a medical man for explaining to his fellows what is the exact use and value of recognised proprietary drugs thus advertised. Does the editor wish to course with the hungry hounds of professional etiquette, and at the same time run with the lucrative hare? Here is indeed a dilemma. Either the journalistic coffers must famish, or the editorial voice be for ever stilled; for, to be consistent, if the advertisers' money be taken, his wares must be recognised and scientifically and accurately investigated and described. To insert whole-page advertisements of a certain preparation for years together at an enormous charge in a medical journal, and then to condemn a medical writer for dealing with them is indeed to play the Pharisee under a cloak of high standard professional ethics.

"Following" the Midwife.

THE attention of our readers may be called to an important letter in our correspondence columns from the pen of Dr. Ward Cousins. No one is more entitled to guide and direct the opinion of the medical profession in this matter than that gentleman. Considering the vital bearing of the Midwives Act upon the everyday practitioner, it is curious how little familiar he is for the most part with the new conditions set up by the Act. It would be interesting to learn the experiences of readers with regard to the Act.

PERSONAL.

HIS MAJESTY THE KING has been graciously pleased to accept a copy of the autobiography of Mr. Frederick J. Gant, just published.

THE late Mr. Joseph George Lambert, after making certain bequests, has left the residue of his estate, probably about £70,000, to King Edward's Hospital Fund for London.

AT a recent meeting of the Dornoch (Sutherlandshire) Town Council, Dr. Jas. MacLachlan was unanimously elected Provost of the Burgh, a rare distinction for a medical man in Scotland.

DR. ERNEST WHITE, who has just retired from the Medical Superintendency of the City of London Asylum after nearly eighteen years' tenure of office, was the recipient of an illuminated address and silver tea and coffee service from the members of the Visiting Committee.

ON the occasion of the opening of the new Public Health Laboratories next week at Manchester University, the honorary degree of D.Sc., will be conferred upon Professor Calmette, Lille University; Professor Perroncito, Turin University; Professor C. J. Salomonsen, Copenhagen University; and Captain Scott, of the *Discovery*.

DR. R. J. D'ARCY IRVINE has been appointed a Senior Medical Officer of the Medical Department of the Gold Coast Colony, and has assumed duty at Accra.

PROFESSOR BRYCE, who recently returned to Plymouth from the Malarial Investigation Commission, is reported to have said that the West Coast of Africa, under common-sense sanitary administration, could be made a health resort like Ias Palmas.

THE Board of Management for the Congrès Internationale de la Tuberculose, which sat on December 20th, 1904, with M. Hérard as President, will be under the distinguished patronage of M. E. Loubert, the honorary presidents being M. Casimir and Léon Bourgeois; the acting president, M. Hérard; Vice-Presidents, MM. Chauneau and Brouardel.

The Congress will be in two parts, M. Letulle acting as Secretary-General, aided by MM. Derecq, Sersirou, and Georges Bourgeois. M. Léon Petit will be responsible for the exhibition, fetes, and receptions of the Congress, and M. Pierre Masson has been elected treasurer.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

SCOTLAND.

LEITH HOSPITAL.—The directors have appointed Dr. W. M. Stewart, who has retired from the acting staff on the completion of fifteen years' service as full surgeon, to be an honorary consulting surgeon to the institution. Mr. A. A. Scot Skiring, F.R.C.S.Ed., has been appointed surgeon to the hospital and Mr. Charles Heron Watson, F.R.C.S.Ed., assistant surgeon, *vice* Mr. Scot Skiring.

Dr. Alexander James has been elected medical officer to the Edinburgh Merchant Company, in room of the late Dr. A. Lockhart Gillespie.

OPENING OF THE GLASGOW WESTERN INFIRMARY DISPENSARY.—For some time the hospital accommodation of the city has been seriously taxed, so much so that at the present time several hundred patients are daily waiting for admission. A new wing is being added to the Victoria Infirmary and with the three hospitals recently erected by the Parish Council, which roughly accommodate two thousand patients, the pressing difficulty is in a fair way of being overcome. The new dispensary of the Western Infirmary was opened on Wednesday last by Lady Blythswood before a company assembled in the waiting-room, which holds over 400. Sir Matthew Arthur occupied the chair, and there were also present Lady Arthur, Sir Lauder Brunton, Sir John and Lady Primrose, Sir Hector Cameron, Principal Story, Dr. H. E. Clark, C.M.G., and others. Prayer being offered by Principal Story, the chairman said that, owing to the large increase of patients requiring treatment in the dispensary of the Western Infirmary, the Medical Committee, in 1892, had reported that the accommodation was inadequate. However, at that time, the Infirmary itself was in even greater need of extension, and so the dispensary had to wait. The fact that the patients were still increasing again forced the matter before the managers, and in 1897 they started a building fund. In response they found themselves with £24,000. Building operations were started in 1902. In 1892, the number of outdoor patients was 12,422, with 38,507 visits, while for last year there were 22,010 patients and 94,235 visits. There was thus a daily average attendance of about 300 patients. Attendance

at the Dispensary is now compulsory for students; and the accommodation for them in the new dispensary is very complete. The estimated cost of the dispensary is about £35,000, so that there still remains about £10,000 to be raised to clear off the debt. The Chairman then called upon Lady Blythwood to declare the building open. Sir Lauder Brunton, M.D., then addressed the meeting. He said he had been in connection with outdoor work at St. Bartholomew's Hospital for twenty-five years, and that during seven he had been seeing from 600 to 800 patients every week. This perfection in waiting-rooms, however, required a large sum of money. He thought that money thus spent would come back bearing fruit tenfold and a hundredfold. The comfort of the patient was increased, and also that of his friends, as he was perhaps saved a serious illness by having his ailment attended to in time. This, of course, lessened the time the patient had to lie up, and therefore gave a greater working power all round, and as the wealth of the country is proportional as the producing power of the people, the patients did not alone benefit by an institution such as this. He then said something besides all this requires to be done. Medicine was not sufficient for the treatment of babes; good food was required and especially good, pure, fresh milk. He wanted it to be possible for mothers to obtain this milk, and this could only be done by some system of inspection of not only city dairies, but also the farms from which the milk came. He also mentioned a National League which had been formed for the purpose of directing physical education and improvement, and commended it to those present.

BELFAST.

THE MILK SUPPLY.—During the past fortnight a lively wordy warfare has been carried on in the public press on this important topic, the leaders being the anonymous writer of an article on "Our Milk Supply" and Dr. Henry O'Neill, who has come forward as a sanitary reformer in the city and in the Municipal Council, of which he is a member. The chief point discussed has been the desirability or otherwise of the sterilisation of milk. Dr. O'Neill has done his best to promote the use of sterilised milk, and to establish a municipal supply of that beverage, but a good many medical men in the city have growing doubts of the advantages derived from its use, and wish to concentrate public effort on the reform of the dairies and proper inspection and control of the supply. The *Northern Whig*, in an exceedingly sensible article on the 21st inst., sums up the discussion and pronounces in favour of the latter view. As it says, it is impossible to sterilise the universe, or banish disease germs from the world, but we can at any rate attend to the laws of Nature and endeavour to obtain our food and drink pure.

THE SMALL-POX EPIDEMIC.—Fresh cases of small-pox continue to crop up every day or two in different parts of the city, and so far all attempts to stamp out the disease have proved unavailing. The civic authorities have issued placards calling attention to the prevalence of small-pox, and to the prime importance of vaccination. The Lisburn Board of Guardians have been much exercised over the question of accommodation for small-pox cases, and have been advised by the Local Government Board Inspector to obtain a loan and build a proper hospital for these cases. They seem rather unwilling to go to the expense, however, and one sapient guardian expressed the opinion that small-pox was not, after all, such a serious matter, as he heard of cases in Belfast which never went to any hospital at all. The matter has been adjourned for further inquiry.

Correspondence.

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

STERILISATION OF CERTAIN DEGENERATES.
To the Editor of THE MEDICAL PRESS AND CIRCULAR.
 SIR,—In your issue of January 18th, "A Student of Sociology" asks me some questions. May I say that

a reply to anonymous critics always brings up to my mind Scott's couplet where he makes Dougal Dalgetty offer to fight his French opponent,

"If you'll only come from behind the door!"

Well, even if this modest correspondent will not come from "behind the door," I must try to reply. He asks, "What would be the fate of anyone who would sterilise a degenerate without the person's consent?" If he refers to his fate in another world, I cannot answer. If he refers to a terrestrial fate, I would reply—Nothing. Parliament never has, nor never will authorise the performance of any operation except hanging—upon any person. The law says any operation is an assault (see Stephens' "Digest of Criminal Law," 4th Ed., p. 148). There is no law empowering any person to perform ovariectomy, or to bring on an abortion in those suffering from kidney or heart disease. Notwithstanding this, if my critic can find time to read Clouston's 6th Edition on "Mental Diseases," p. 578, when treating of puerperal insanity, he will find Dr. Clouston saying: "I think that abortion should be resorted to if marked insanity comes on in the early stage of pregnancy. . . In the later months, too, premature labour should, I think, be induced." Here is an authority recommending the killing of children in the womb. I only assert that we should excise and ligature the Fallopian tubes. My proposal is evidently too mild! My critic, in his further remarks, deals with the future. I prefer to deal with the present. I have gone to great trouble to show that there were, on one day in 1901, no less than 177,995 mentally deranged persons in the United Kingdom; that of 117,274 lunatics, 48,800 were married or widowed; that of 60,721 idiots and imbeciles, 18,900 were married or widowed; that this is a bad stock to breed from; that we have 11,238 deaf, mostly deaf mutes; that we are annually spending about £20,000,000 upon degenerates; that we are allowing idiots, imbeciles, and lunatics to marry and to beget offspring; that we allow the insane, liberated from asylums, to resume marital condition; and the fact that while we limit the birth-rate of those best qualified to beget healthy offspring, we allow the most degenerate part of the nation to breed indefinitely. This, to some, may be quite correct. I do not agree.

My critic evidently holds in high regard the 670 members of the House of Commons and makes me tremble (!) by asking me to think of "their shouts of laughter," if a Bill to legalise sterilisation were introduced. Surely he has a higher opinion of M.P.'s than he asserts.

Some 2,000 males and females are sterilised by surgeons in England yearly. If my critic will do me the great honour to look into my monograph on "Proposed Sterilisation," he will find that I also call attention to our disgusting law which provides that children of fourteen and twelve can legally marry; that we allow syphilitics and other physical deteriorates to marry; that we make it illegal, for the healthy, in many occupations, to marry; and that a diseased person must either marry or pay if he refuse to marry the woman to whom he is engaged.

Will you allow me to add, sir, that I am more than tired—being one in general practice and not a mere specialist—of this correspondence with "students," and that I think they ought to work up this subject of degeneration before putting one to the trouble of reply.

I am, Sir, yours truly,
 ROBERT R. RENTOUL.

Liverpool.

HOSPITAL REFORM.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.
 SIR,—There is not the least doubt but that there is a good deal to be done before the hospital system of London is in a satisfactory state. Mr. Sewill's views are those of a good Conservative. We have begun this century in a spirit of reform. Our army, our navy, our system of education, our laws, &c., &c., are all being criticised and amended. Some suffer sadly

and have to bear the brunt of the changes and the consequences of the faults of others. As regards our hospitals, it is rather sad, but not surprising to see how Sir Henry Burdett and the Hon. Sydney Holland differ; how Bartholomew's and Sir Trevor Lawrence have somehow gone off the stage in a very quiet way; how the Hospital Sunday Fund and the King's Fund are in a kind of competition for public support; and how the hospitals are all devising new ways and means to get funds to keep them out of difficulties. What will be the end of it all is not very clear.

Hospitals are peculiar advertisements to reputation for those connected with them, both lay and professional. The committees and their chairmen, the medical elements of these charitable institutions, the nurses or sisterhoods and their duties, are influenced more or less by other sentiments and motives than those of charity—that is, the good of others. We want a little reform in this rather questionable spirit of push and advertising that for some years has prevailed in this country. It is well for Mr. Sewill and men like him not to think they know when they don't.

I am, Sir, yours truly,

REFORM.

"FOLLOWING" THE MIDWIFE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your remarks in THE MEDICAL PRESS AND CIRCULAR of last week upon the "unenviable notoriety of the doctor when called to assist a midwife and relieve her of the onus of a bad case which has been too long untreated," very correctly state the experience of many practitioners throughout England and Wales, who have often been summoned to poor women in a dangerous and sometimes hopeless condition through the ignorance and neglect of unqualified persons.

It is, however, a matter of great satisfaction to know that, by the salutary operation of the Midwives Act of 1902, this kind of "following the midwife" will soon be a thing of the past, and that incompetent and unqualified persons will no longer infest the homes of the poor parturient women of our country. There are already nearly 9,000 certified midwives admitted on the first Midwives Roll, and these women are permitted to undertake only normal labours, and that in every case presenting any unusual feature or any abnormality occurring during pregnancy, labour, or lying-in, they are bound to obtain the assistance of a registered medical practitioner. Their practice is surrounded by wholesome restrictions, and they are strictly prohibited by law from writing any certificate of still-birth, or any certificate of death, or any other form of medical certificate—a practice which has been carried on without any limitation by many ignorant women who have had the audacity to call themselves "midwives."

It is true that the Midwives Act of 1902 requires amendment in many details; still, we may anticipate with confidence that this imperfect enactment will bring about a great and salutary reform in the practice of midwifery throughout the country.

In conclusion, I beg to inform my professional friends who have not yet read the Act and the Rules framed by the Central Midwives' Board, that a copy may be obtained at a trifling cost from the secretary of the Board, 6, Suffolk Street, S.W.

I am, Sir, yours truly,

J. WARD COUSINS,

Representative of the R.C.S. on the Central Midwives Board.

January 23rd, 1905.

SCOTCH QUALIFICATIONS AND LONDON HOSPITALS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Personally, as an Englishman holding a Scotch diploma, I am deeply grateful to you for bringing forward this subject. The hospital men of London have, naturally enough, sought to keep a good thing to themselves by a trades unionism of the grossest nature. It is only in the small hospitals, which the

Sunday and the King Edward's Funds apparently want to put out of existence, that the Scotch diplomat has his chance. Now that a powerful association of Scotch diplomates has been formed there is every hope that the public will be fully informed as to the injustice going on in the hospitals supported by their money.

I am, Sir, yours truly,

NORTHERN SCALPEL.

Obituary.

DR. OWEN M. PRAEGER.

A PAINFUL sensation has been caused in Belfast by the sad, self-inflicted death of a well-known and much esteemed young medical man. Dr. Owen M. Praeger, who was resident physician in the fever hospital at the Union Workhouse, was, on the afternoon of January 16th, found lying on the bed in his room, dead, with a bottle which had contained prussic acid near him. The *post-mortem* examination made it quite clear that death was caused by poisoning. Dr. Praeger, who was thirty-one years of age, was a native of Holywood, co. Down, and a member of a family well known in Belfast in connection with literary and scientific pursuits. His uncle, Sir Robert Patterson, is a prominent man in Belfast life, and his brother is well-known in Dublin, where he holds a post at the National Library. Dr. Praeger was educated at Queen's College, Belfast, and took his degree about four years ago in the Royal University of Ireland. Since then he has been resident in the fever hospital, except that for some months last year he was on special duty at the small-pox hospital at Purdysburn. About a year and a half ago he lost one eye as the result of an accident, and it is suggested that his mind may have brooded over this, and the consequent disfigurement. He seemed, however, in excellent health and spirits, and no motive is known for the rash and sad act which terminated his career. He was a great favourite with all with whom he came in contact, and his tragic end is deeply regretted.

WILLIAM MOORE, M.B., C.M., GLASGOW, OF AYR.

The death is announced of Dr. William Moore, M.B., C.M., Medical Officer for Ayr, of pneumonia, after a brief illness on the 16th inst. A native of Newmilns, Dr. Moore first came to Ayr twenty-five years ago as house surgeon to the County Hospital. He graduated M.B. at Glasgow University in 1876. Besides a considerable private practice, Dr. Moore was Medical Officer for the Foresters' Friendly Society and held an appointment under the Factory Act. He was fifty-two years of age, and is survived by a widow and four children.

Literature.

WINGRAVE ON ADENOIDS. (a)

THE time is long past when it was necessary to adduce arguments to prove the existence and the harmful effects of post-nasal adenoid vegetations; indeed, most practitioners of the modern school are quite alive to the importance of diagnosing and removing the growths in question. This well-printed and otherwise commendable monograph gives a very clear idea of the condition and of the means of getting rid of the obstruction caused by the presence of the characteristic proliferation. An excellent idea of the *facies* of young subjects of respiratory obstruction, due to this cause, is conveyed by the photographs reproduced in illustration thereof, and the volume of the growths occasionally met with is testified to by the very telling photograph on the first page.

The principal question that the practitioner is called upon to decide is as to the propriety of operating in a given case, and opinions differ widely in respect of

(a) "Adenoids." By Wyatt Wingrave, M.D., Physician and Pathologist, Central London Throat and Ear Hospital. (Medical Monograph Series, No. 9.) London: Baillière, Tindall and Cox. 1904. Price 2s. 6d. net.

the degree of obstruction that may be held to justify operative interference. Certainly the mere presence in the naso-pharynx of a child of a certain amount of lymphoid over-growth, not attended by troublesome local or constitutional symptoms, is not of itself an indication for operation, and the author is careful to insist on the collateral conditions that render removal a matter of urgent necessity. The fact that in a certain proportion of cases masses of adenoids have virtually cleared up soon after the age of puberty, hardly affords sufficient reason for "waiting to see" in the majority. The author does well to point out that although a comparatively trifling operation, the removal of large adenoid masses is a very sanguinary, and sometimes a distressing, operation. The rough or inexperienced operator can do a great deal of harm in a short time, to say nothing of the risks inherent to general anæsthesia in these subjects.

Within the compass of this short monograph the author practically exhausts the subject, and has written a work worthy to rank with its predecessors in the series.

REPORTS OF THE TRYPANOSOMIASIS EXPEDITION. (a)

This volume consists of a series of reports of the investigations which have been carried on by the Liverpool School of Tropical Medicine into the subject of human trypanosomiasis in the Congo Free State. Some of the individual papers have already been published in various medical journals, but gathered together as they now are, they constitute a work of high scientific importance, and one of which the Liverpool School may be proud.

An expedition was first sent to the Congo from Liverpool in September, 1903, at the request of King Leopold, of Belgium, and as early as January, 1904, a report was published containing as its most important conclusions the statement (1) that the trypanosome found both in cases of simple trypanosomiasis and of sleeping sickness in the Congo was identical with the *Trypanosoma Gambiense*; and (2) that somnolence was a comparatively rare symptom of "sleeping sickness." At the time of this first progress report, 707 individuals had been examined. This number has been now increased to 1,172, and the extended experience has enabled the first conclusions to be amplified and confirmed both in Africa and, experimentally, in Liverpool. Some details of the clinical symptoms of trypanosomiasis are also given, and the disease is divided into three stages according to the severity of its manifestations; the last stages appear to correspond to what is known among the natives as "sleeping sickness." The writers point out that "in nearly every case in which sleeping sickness was diagnosed or suspected, trypanosomes have been found either in the blood, cerebro-spinal fluid, or both," but add the important statement that as yet there is not sufficient evidence to prove that death is produced by trypanosomes alone, and that in almost every fatal case, some secondary bacterial infection is found. The special report by Christy on the cerebro-spinal fluid in sleeping sickness is of great interest, and as far as it goes shows that the symptoms of the disease are not definitely related to the presence of trypanosomes in this fluid as distinct from their presence in the body generally.

In addition to the direct work on trypanosomes, the volume contains papers on the "Congo Floor Maggot," and on the "Tse-tse Flies." Both of these have been published before, and need not be referred to, further than to say that their inclusion in the present report is an evidence of the comprehensive manner in which the problems of tropical disease are now being attacked.

DISEASES OF WOMEN. (a)

THERE is a refreshing originality in the way the authors handle a subject which, until quite recently, was made up of a very small proportion of certain knowledge, embedded in an unlimited quantity of "dogmatic theory." To Mr. Bland-Sutton and to the late Mr. Lawson Tait we are indebted in great measure for the sweeping away of the ambiguities that hindered the study of gynecology. The result is seen in the severe cutting down of chapters on such subjects as uterine displacements, to which in years gone by an overweening amount of space was given, and the great extension given to the etiology, diagnosis, and treatment of diseases of the uterine adnexa, ectopic gestation, and cyst formation.

The present edition is in many ways an improvement on its predecessors. Various lapses have been remedied, and redundancies have been rigorously eliminated. It is now a practical treatise on gynecology, better fitted perchance for the practitioner than for the student, since the latter may meet at the examination-table specialists in this department who belong to another century, and who resent the substitution of the scalpel for time-honoured dilatory procedures.

We concur in the authors' view that "when surgical authors are able to restrain their vanity and refrain from publishing notes of successful cases in text-books, the established facts of the art can be presented in a very convenient compass." In some 500 pages of large and well-led type they have covered the whole ground, and this in a manner that, technically, leaves nothing to be desired. The literary style is at times a trifle rough. Why, for instance, do they use "superiorly" and "inferiorly" instead of the much more convenient and simpler terms, "above" and "below"? We miss many illustrations from former editions, their place, or that of some, being taken by new ones. One may question the value to the reader of illustrations of cysts, ruptured tubes, and the like, for they really convey no very clear idea of the actual specimens, and throw no particular light on the text—which, indeed, stands in little need of such elucidation. There are numerous well-thought-out tabular statements of points to be borne in mind in considering the diagnosis, and altogether the work is one which does credit even to such an able surgeon as Mr. Bland-Sutton, flanked by his talented coadjutor.

DISEASES OF THE EAR. (b)

IN these days when every surgeon who devotes his attention to a special region of the body finds himself obliged by force of example to write a book on his subject, it is hardly to be expected that each new volume will teem with original research or fresh information. Dr. Kerr Love's book, which we have before us, contains a plain, straightforward account of the anatomy, pathology, and diseases of the ear. In a book of this size we should have expected a somewhat fuller discussion of the details of some of the conditions than we actually find. For instance, the relation of ear disease to life assurance is dealt with in a simple page, and the ear complications of the infectious diseases are dismissed in a bare half-page. It is true that reference is made again to the latter subject latter on, but the information given is scrappy, and the statement that "the acute mastoiditis which follows scarlet fever is very amenable to surgical treatment," will hardly accord with the experience of many other aural surgeons, we fancy. The great value of the book, however, lies in the elaborate and beautifully-executed series of stereoscopic plates illustrating the anatomy of the temporal bone and auditory apparatus, together

(a) "The Diseases of Women: A Handbook for Students and Practitioners." By J. Bland-Sutton, F.R.C.S., and Arthur E. Giles, M.D., B.Sc. Lond., F.R.C.S. Ed., Surgeon to Out-Patients, Chelsea Hospital for Women, and Gynecologist to the Tottenham Hospital. Fourth Edition. London: Rebnan Ltd.

(b) "Diseases of the Ear." By James Kerr Love, M.D., Aural Surgeon, Glasgow Royal Infirmary. With Fifty-four Stereoscopic Photographs, Two Coloured Plates, and many Illustrations. Bristol: John Wright and Co. 25s. net.

(a) "Liverpool School of Tropical Medicine.—Memoir XIII. Reports of the Trypanosomiasis Expedition to the Congo, 1898-1904." By J. Everett Dutton, M.B., John I. Todd, M.D., and Cuthbert Christy, M.B. With a Comparison of the Trypanosomes of Uganda and the Congo, by H. W. Henslow, Thomas and Stanley Linton, and a Note on Tse-tse Flies, by E. E. Austin. London: Williams and Norgate.

with some of their diseases. The preparations from which the photographs were taken are excellent, and the fidelity of their reproduction irreproachable. Nothing more accurate or realistic than these plates is to be found in the annals of British aural surgery. It remains only to be said that the paper, printing, and general get-up of the book render it a veritable edition *de luxe*.

NORMAN WALKER'S DERMATOLOGY. (a)

THE appearance of the third edition of this popular handbook should serve to further stimulate the interest of practitioners and students in the somewhat unattractive sphere of skin diseases. The opinion that this work may be taken as "a concise and accurate guide" in the subject with which it deals, which we expressed concerning previous editions, remains unaltered to-day. Considering what a useful adjunct the X-Rays are to dermatological therapeutics, it is not surprising to find that a good deal of space is devoted to accounts of this comparatively new mode of treatment. The author is not prepared to recommend the rays as a routine treatment in ringworm of the scalp, but he has seen them produce a rapid disappearance of patches of psoriasis. This latter disease is considered to be an "extremely dry form of seborrhœa," an opinion which is not shared by the majority of dermatologists in this country, although it is true, of course, that there are many cases which seem to lie on the borderland between psoriasis and seborrhœa. The treatment of lupus occupies eight pages, and is very thoroughly dealt with. The effect of radium, especially upon patches upon the palate, is highly spoken of, and a brief reference is made to the possible therapeutic uses of uranium in this affection. The unusual course is still adopted of describing the *pediculus corporis* under the heading of "Anomalies of Circulation" as a purpuric manifestation. Without being too tied and bound to the slavery of classification, this book is eminently readable. The photographic illustrations are excellent, but we cannot say the same of the coloured plates.

BERRY ON SURGICAL DIAGNOSIS. (b)

THERE is as much difference between surgery taught in systematic treatises and actual diagnosis as there is between learning to read a language and trying to speak it. Moreover, the knowledge of anatomy and surgical pathology which medical students acquire is of use only so far as it enables them to arrive at a correct diagnosis as a preliminary to treatment. The diagnosis of abnormal conditions is, therefore, a subject in itself, and may advantageously receive special treatment. No excuse is needed consequently for this work, nor for the fact that the author makes no pretence to having covered the whole ground of surgical diagnosis.

Turning to the text we find that it really does not go beyond the principles and facts which every surgeon, old and young, must have in mind when he sets himself the task of deciding the nature, origin, and probable result of a given lesion. The first fact that the student has to grasp is that "all that glitters is not gold," and that things are often not what they seem. Nothing is more difficult to the beginner and the inexperienced than to keep an open mind until data sufficient to establish a diagnosis have been obtained, he is but too apt to "form an opinion" early in the course of his examination, and to allow that immature judgment to influence his subsequent steps.

The author endeavours to impress the reader with the necessity of having all the possible interpretations of a given group of symptoms present in the mind before deciding in favour of only one of them—this is "diagnosis by exclusion," the only safe method for general

use. Doubtless, many a student will remark how simple, how obvious are the points to which attention is directed, but the important thing is to have them before one in forming an idea of the significance of the various symptoms and physical signs. By restricting himself to the minor points the author has been enabled to keep the book of moderate dimensions.

The work will be of service to others than students. Many a practitioner will derive material assistance in obscure cases by looking up the directions given for the differential diagnosis. The author shows him how to obtain practical experience, although he cannot confer the *tactus eruditus*, charm he never so wisely. We feel confident that Mr. Berry's work will become popular by reason of its limitations and practical bearings.

LAMB'S EXAMINATION OF THE THROAT, NOSE, AND EAR. (a)

THIS is a book which we have long been looking for in vain. It has always surprised us that no one, until now, has written a short work on a subject of daily interest to practitioners. The author's aim has been to provide an extremely elementary handbook. A brief introduction describes the position of the examiner, and the use of the mirror or reflector. In the chapter on the examination of the pharynx the author gives a clear account of the anatomical points of importance. The mode of examination is accurately described, and the various abnormal conditions likely to be met with pointed out. In considering the examination of the nose, Dr. Lamb gives an excellent summary of the anatomy of this region, illustrated by a number of very practical diagrams. The method to be adopted in examining the nose is fully detailed, and the morbid changes likely to be present are described.

Personally, in teaching students we have found that the examination of the larynx usually presents the most difficulty. A study of the remarks made by the author and the hints which he gives will do much to simplify this process; although the reader must not content himself with the mere theory of the subject. The commoner affections of the larynx are considered somewhat briefly, but quite sufficiently for all practical purposes. The description given in the chapter on the examination of the ear, of the various tests usually employed for purposes of diagnosis is written in plain language which any average student can understand. The method of Politzerisation is briefly referred to, and the use of the Eustachian catheter is very fully described. Siegel's suction speculum and the aural conditions in which it is of special value as a diagnostic are mentioned. The chapter on local treatment is very readable, and bristles with most valuable therapeutic suggestions.

A careful perusal of this practical guide convinces us that it meets a much felt want. There are many cases occurring in every-day practice which remain undiagnosed simply because the practitioner has not had the advantage of training in the examination of the throat, nose and ear. By following out the directions given by Dr. Lamb no one of average intelligence can fail to succeed in carrying out the necessary examinations of these organs. We have seldom read so practical a guide on any subject connected with medical practice, and we have no hesitation in expressing the opinion that this small text-book will become a general favourite with senior students and practitioners.

Medical News.

The Laryngological Society of London.

At the annual meeting of this Society on the 13th inst., held at 20 Hanover Square, the following officers were duly elected to serve during 1905:—*President*: Charters J. Symonds, F.R.C.S. *Vice-Presidents*: W.

(a) "An Introduction to Dermatology." By Norman Walker, M.D., F.R.C.P.E. Third Edition. Pp. x and 284. Price 9s. 6d. net. Bristol: John Wright and Co. London: Simpkin, Marshall and Co.
(b) "A Manual of Surgical Diagnosis." By James Berry, B.S., F.R.C.S., Surgeon to, and Lecturer on Surgery at, the Royal Free Hospital, &c., &c. London: J. and A. Churchill, 1904. 6s. net.

(a) "Guide to the Examination of the Throat, Nose and Ear for Senior Students and Junior Practitioners." By Wm. Lamb, M.D., C.M. Edin., M.R.C.P. Lond., Honorary Surgeon, Birmingham Ear and Throat Hospital. Pp. xii, 152, with 32 Illustrations. Crown 8vo. London: Baillière, Tindall and Cox. 1904. Price 6s. net.

Milligan, M.D., F. Willcocks, M.D., J. B. Ball, M.D., William Hill, M.D. *Council*: L. H. Pegler, M.D., J. Walker Downie, M.B., P. McBride, M.D., W. R. H. Stewart, F.R.C.S., Felix Semon, C.V.O., M.D., E. Furniss Potter, M.D. *Hon. Treasurer*: H. B. Robinson, F.R.C.S. *Hon. Librarian*: StClair Thomson, M.D. *Hon. Secretaries*: P. R. W. de Santi, F.R.C.S., and H. J. Davis, M.B., M.R.C.P.

A Dentistry Degree.

THE Court of the Manchester University last week unanimously approved a resolution, moved by Prof. Stirling, to put into effect the ordinances for degrees and diplomas in dentistry. Prof. Stirling explained that the scheme had been prepared by their dental colleagues, and carefully considered by the medical faculty at several meetings. It established degrees and diplomas in dentistry, thus removing from dental students in this part of the country the disability under which they had laboured in having to go to London to be examined. A dental student, before obtaining a licence to practise, would have to study for four years.

Congress of School Hygiene.

THE French Congress of School Hygiene will hold its second meeting at Paris in June, 1905. The following is the programme:—(1) The medical inspection of primary schools; (2) the education of families in school hygiene; (3) vacations and holidays; (4) tuberculosis and teachers; (5) the over-loading of school courses and competitions for admission to large schools. Professors Debove, Grancher, Landouzy, and Pinard are honorary presidents of the Congress. All communications should be addressed to Dr. I. Ch. Roux; 46 Rue de Grenelle, Paris.

International Congress of Obstetrics and Gynaecology.

THE fifth meeting of the International Congress of Obstetrics and Gynaecology is to be held at St. Petersburg from September 11th to 18th of the present year. The principal subjects proposed for discussion are (1) *Accouchement forcé*; (2) the operative treatment of fibro-myoma of the uterus; (3) vaginal methods of operation in obstetrics and gynaecology; (4) critical discussion of the operative procedures for retro-deviations of the uterus; (5) chorion-epithelioma.

International Congress of Psychology.

THE International Congress of Psychology holds its fifth meeting this year at Rome, April 26th to 30th. There will be four sections: Experimental Psychology, under Professor G. Fano, of Florence, will deal with psychology in its relations to anatomy and physiology, psycho-physics and comparative psychology. Introspective Psychology, under Professor R. Ardigò, of Padua, devotes itself to psychology in its relations to philosophical sciences. Pathological Psychology, under Professor E. Morselli, of Genoa, will discuss hypnotism, suggestion, and analogous phenomena, and psycho-therapeutics. Criminal, Pædagogic, and Social Psychology will be under the presidency of Professor Lombroso, of Turin. The official languages of the Congress are Italian, French, English, and German. The President of the Congress is Professor Giuseppe Sergi of Rome; the General Secretary Dr. Sante de Sanctis, to whom all communications should be addressed at the Instituto Fisiologico, 92 Via Depretis, Rome.

Is Leprosy Curable?

It is announced that treatment with leprolin, the new serum prepared by Captain Rost, I.M.S., is being tried in several of the Indian Asylums of the Mission to Lepers. At Purulia, in Bengal (where the Society supports 600 lepers), three cases are declared by the Deputy Sanitary Commissioner of the district to be "to all intents and purposes completely cured." Others show less favourable results. The hopeful cases will be isolated and observed for six months before a final decision can be pronounced. If found to be of lasting benefit, the Society will adopt the treatment in others of its forty-two asylums in India and the East. Meanwhile, it is hopeful to have Dr. Wilson (of Miraj, Bombay Presidency) saying, "There is no

doubt that Dr. Rost has made a very great discovery, and again opened the door of hope to the lepers."

Welfare Work.

ONE of the promising movements of modern times towards the moral, intellectual and physical betterment of employes is known by the name of Welfare Work. As a rule, a welfare manager is appointed. He is a recognised intermediary between employer and employed, and his exclusive duty is the improvement of the conditions of workers. Many great industrial concerns in America have joined this movement. Amongst English firms that have gained an international reputation for welfare work are Messrs. Cadbury Brothers, Ltd., Lever Brothers, Ltd., and Burroughs Wellcome and Co. In America, the National Cash Register Co. was the pioneer of all welfare work. A convention of Continental and district managers of the N.C.R. Co. is being held in London, and last week appropriately visited the Wellcome Club at Dartford, an institution provided by Mr. Henry S. Wellcome for the 1,200 employes of Burroughs Wellcome and Co., the wholesale druggists.

PASS LISTS.

Royal College of Surgeons of England.

THE following, having passed the necessary examinations, and conformed to the by-laws and regulations, have been admitted Fellows of the College and have received their diplomas:—J. E. Adams, L.R.C.P. Lond., St. Thomas's; K. Black, L.R.C.P. Lond., L.D.S. Eng., Guy's; A. R. Brailey, M.A., M.B., M.C. Camb., Guy's; J. H. Burgess, M.B. Lond., Lieut. I.M.S., St. Mary's; E. R. Carling, M.B., B.S. Lond., Westminster Hospital; N. Carpmal, L.R.C.P. Lond., St. Thomas's; J. Clay, M.B., B.S. Durh.; W. F. H. Coke, L.R.C.P. Lond., St. George's; H. Davies-Colley, B.C. Camb., Guy's; R. C. Elmslie, M.B., B.S. Lond., St. Bartholomew's; T. J. Faulder, L.R.C.P. Lond., Camb., and St. Bartholomew's; R. J. Ferguson, M.D., M.Ch. R.U.I., King's College and Middlesex Hospital; C. B. Goulden, M.B., B.C. Camb., Middlesex Hospital; W. L. Harnett, M.B., B.C. Camb., St. Thomas's; F. J. Hasslacher, M.B. Lond., King's College Hospital; S. Hastings, M.B., B.S. Lond., Middlesex Hospital; J. A. Hayward, M.D. Lond., St. Bartholomew's; H. A. Lyth, M.B., B.S. Lond., University College Hospital; D. J. McGavin, M.D. Lond., Mason College, Birmingham and London Hospital; A. McNab, M.B., Ch.B. Ed., London Hospital; C. E. Marriott, M.C. Camb.; A. T. Moon, L.R.C.P. Lond., London Hospital; F. H. Parker, M.B., B.C. Camb., Guy's; H. D. Pollard, M.B. Lond., London Hospital; W. A. Rees, M.B. Lond., Middlesex Hospital; N. I. Spriggs, M.B., B.S. Lond., Guy's; H. B. Tawse, M.B., Ch.B., Aberd., London Hospital and King's College, London; H. Upcott, L.R.C.P. Lond., St. Thomas's; N. E. Waterfield, M.B. Lond., St. Bartholomew's; G. E. Waugh, M.D. Lond., Camb., and University College Hospital; and C. F. Walters, L.R.C.P. Lond., University College and Royal Infirmary, Bristol, and King's College, London.

Society of Apothecaries of London, January, 1905.

THE following candidates have passed in:—
Surgery.—T. H. Jones (Sections I. and II.), R. C. Richards (Section I.), A. M. Walker (Sections I. and II.), J. M. Wall (Sections I. and II.).
Medicine.—J. B. Bradley (Section I.), P. F. Howden, T. H. Jones (Sections I. and II.), T. R. Roberts (Section II.), J. H. K. Sykes (Sections I. and II.), M. C. Vivian (Section I.).
Forensic Medicine.—A. B. Gosse, M. E. Jeremy, T. H. Jones, J. H. K. Sykes.
Midwifery.—C. G. Grey, M. E. Jeremy, T. H. Jones, A. M. Walker, P. C. West.
 The Diploma of the Society was granted to the following candidates entitling them to practise Medicine, Surgery, and Midwifery:—P. F. Howden, M. E. Jeremy, T. H. Jones, and A. M. Walker.

Notices to Correspondents, Short Letters, &c.

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

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.

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 re-forwarding 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.

"THE IMMEDIATE REPAIR OF LACERATION OF THE PERINEUM."

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

Sir,—The heading of Dr. Laphroth Smith's paper seems rather anomalous, as he introduces sutures in cases where no "repair" may be required.

"Meddlesome midwifery is bad."

To stitch when there's no tear is sad.

That wretched rhyme,

("A stitch in time")

I don't consider fair.

Such is abused

When it is used

When there exists no tear.

If parts are stretched, and muscles tired,

You'll find no stitching is required.

Yours, &c., A.D.

G. P. (Croydon).—The question often arises. If your patient went to the consultant repeatedly without your knowledge he can hardly be blamed for attending her at her own house when requested. From the facts as laid before us we should think there would be little advantage in standing upon one's dignity in the matter. At the same time there will be no harm in your writing to the consultant fully upon the point.

WANDSWORTH.—The best man to call in is an authority upon the action of poison, as his evidence will naturally carry most weight both with judge and with jury.

SPECIALIST.—Your remedy lies in a court of law, that is, if you can definitely trace the authorship, and prove the utterance of the slander. If you take our advice, however, you will let the matter drop, rather than slide into the possibly bottomless pit of litigation.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JANUARY 25th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. M. Collier: Clinique. (Surgical.) 5.15 p.m. Mr. E. T. Collins: Glaucoma (with lantern illustrations).

CENTRAL LONDON THROAT AND EAR HOSPITAL (Gray's Inn Road, W.C.).—5 p.m. Demonstration.—Dr. Wylie: Naso-Pharynx.

THURSDAY, JANUARY 26th.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—8.0 p.m. Card Specimens will be shown by Dr. L. Cole-Baker and Mr. W. H. Jessop. 8.30 p.m. Papers: Dr. F. Ferguson: A Case of Malignant Disease of the Conjunctiva.—Mr. A. Lawson: Treatment of Corneal Ulcers with Quinine.—Mr. O. Worth: Notations of Prisms.—Dr. D. J. Wood: Two Unusual Cases of Detachment of the Retina.]

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Titchborne Street, Edgware Road, W.).—8 p.m. Clinical Evening. Patients in attendance at 8 p.m.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC, 22 Chenies Street, W.C.—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Mr. E. Willett: Anaesthetics.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Mr. H. W. Carson: The Present Position of Gastric Surgery.

MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST (7 Fitzroy Square, W.).—5 p.m. Lecture: Dr. J. E. Squire: Adventitious Sounds in the Pulmonary Disease and their Significance. (Post-Graduate Course.)

FRIDAY, JANUARY 27th.

CLINICAL SOCIETY OF LONDON (20 HARVEY SQUARE, W.).—8 p.m. Exhibition of Clinical Cases followed by Discussion. Patients will be in attendance from 8 to 9 p.m.

PHARMACEUTICAL SOCIETY OF GREAT BRITAIN (17 BLOOMSBURY SQUARE, W.C.).—8 p.m. Papers:—1. Prof. A. W. Cromley: Pharmaceutical Regulations in Germany.—Mr. P. H. Martden: The Laws Relating to Pharmacy in Russia.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. L. Paton: Clinique. (Bye.)

TUESDAY, JANUARY 31st.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Mr. H. W. Carson: Diseases of the Naso-Pharynx.

Vacancies.

Leeds General Infirmary.—Resident Medical Officer. Salary £100 per annum, with board, residence, and washing. Applications to the Secretary to the Faculty.

Monmouthshire Asylum, Abergavenny.—Junior Assistant Medical Officer. Salary £150 per annum, with board, lodging and washing. Applications to the Medical Superintendent.

County Asylum, Eainhill, near Liverpool.—Assistant Medical Officer. Immediately. Salary £150 per annum, with furnished apartments, board, attendance, and washing. Applications to the Medical Superintendent.

Bolton Infirmary and Dispensary.—Junior House Surgeon. Salary £100 per annum, with furnished apartments, board and attendance. Applications to the Hon. Secretary, W. W. Canon, Esq., 20 Maudslay Street, Bolton.

Manchester Hospital for Consumption and Diseases of the Throat, and Chest.—Resident Medical Officer. Salary £100 per annum, with board, apartments, and washing. Applications to C. W. Hunt, Secretary, Hardman Street, Deansgate, Manchester.

Manchester Children's Hospital, Pendlebury.—Lady Superintendent. Salary £100 per annum, with board, rooms, washing, and attendance. Applications to the Secretary.

Liverpool Dispensary.—Assistant Surgeon.—Salary £100 per annum, with board and apartments. Applications to Sam E. Leicester, Secretary, 56 Vauxhall Road, Liverpool.

Chester General Infirmary.—House Surgeon. Salary £100 per annum, with residence and maintenance in the house. Applications to the Chairman of the Board of Management.

Ancoats Hospital, Manchester.—Resident House Surgeon. Salary £100 per annum, with board, residence, &c. Applications to Saml. Baron, Secretary.

Sunderland Infirmary.—House Physician, House Surgeon, Assistant House Surgeon. Salary £100 per annum, with board, residence and washing. Applications to the Secretary.

East London Hospital for Children, and Dispensary for Women, Shadwell, E.—Pathologist and Registrar. Salary £100 per annum. Applications to Thomas Hayes, Secretary.

Egyptian Government—Ministry of Public Instruction.—Professor of Pathology and Bacteriology at the School of Medicine, Cairo. Salary £200 per annum, private practice not allowed. Applications to the Director, Government School of Medicine, Cairo, Egypt.

North of Ireland.—R. C. Doctor for a good practice. D., Dublin Office of this paper. (See Advt.)

Appointments.

HOBSON, H., M.B., M.S. Lond., Certifying Surgeon under the Factory Act for the Alresford District of the county of Hants.
SCOTT, C. E., M.B., C.M. Edin., Certifying Surgeon under the Factory Act for the Abingdon District of the county of Berks.

Births.

BLAKE.—On Jan. 13th, at Bentley, Maidstone Road, Grays, Essex, the wife of Anthony Fewster Blake, M.R.C.S. (late of Nailsworth, Glos.), of a daughter.

Marriages.

BROCKWELL—SMITH.—On Jan. 18th, at Christ Church, Gipsy Hill, John Brocas Chambers Brockwell, M.R.C.S. and L.R.C.P., eldest son of the late Dr. John Brockwell, of Gipsy Hill, S.E., to Annie Amelia, elder daughter of the late William Edwin Smith, of Lewes, Sussex.

McHATTIE—BRADOR.—On Jan. 18th, at Portland, Dorset, A. C. N. McHattie, M.B., of Haxey, Lincolnshire, to Alice, youngest daughter of the Rev. Canon and Mrs. Beason, The Rectory, Portland.

Deaths.

PENNY.—On December 19th, near Mombasa, British East Africa, William John Penny, F.R.C.S., formerly of Clifton, Bristol, and eldest son of William Penny of Crewkerne, Somerset.

WEST.—On Jan. 18th, at 16 Church Square, Taunton, Rowland Hill West, M.A., Cantab., M.R.C.S., L.R.C.P., L.R.C.A., Cert. Fact. Surg., aged 62.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXX.

WEDNESDAY, FEBRUARY 1, 1905.

No. 5.

Original Communications.

THE VALUE OF SCIENTIFIC METHOD IN THE STUDY OF LARYNGOLOGY. (a)

By CHICHELE NOURSE, F.R.C.S. Edin.

Surgeon to the Central London Nose, Throat, and Ear Hospital.

NEEDLESS to say, for the healthy and vigorous existence of a Society like this the co-operation of every member is needed; moreover, it is a duty incumbent upon all engaged in the study of any branch of medicine to contribute what we can to the common store of knowledge. Our first illustrious President, Sir Morell Mackenzie, spoke of this duty in the able and eloquent Address, pregnant with suggestions for his younger *conferres*, with which he inaugurated the work of the opening session of this Association, the oldest of the kind in the United Kingdom. He, with some of those who heard him, has passed away; but his words remain. "Those," he said, "who are content perseveringly to interrogate Nature in her everyday dress will, I am persuaded, be fully compensated for such courageous humility. . . Work steadfastly, then, whether the subject be recon-dite or apparently trivial. Observe and test everything, and bring your results here to be criticised by your fellow-workers." Those are his words. Since that time much has been accomplished, but there is still work for us to do; now, I think, more than ever, for, with deeper insight, the complexity of the subject is more clearly seen, and new factors, hitherto unsuspected, appear in view.

Our field of work, it is true, is in part overlapped by that of each of our distinguished sister-societies; but, considering the increasing importance of that field, the rapidly-growing band of workers, the more numerous hospital clinics, and the ceaseless activity of research and observation in every direction, there must be ample material in this Metropolis alone to supply even more societies than those already existing. Moreover, it is of advantage, both to the medical profession and to the community at large, for the sake of greater freedom of thought, that there should be more centres than one for the record of observations and for the discussion of interesting questions. It will, I hope, be demonstrated by the work of the present session, as it has been in the

past, that there is among us the same enthusiasm for good work which characterised the Association in the first flush of its youth, when those distinguished workers, now, alas, no more, were still with us. In a few weeks' time the Association will be called upon to join with the Laryngological Society of London and the other laryngological societies of the world in celebrating the hundredth birthday of Señor Manuel Garcia, the inventor of the laryngoscope, to whom we have already paid a tribute in electing him an Honorary Fellow. It was fifty years ago that the desire of studying the action of the larynx during singing led him to devise the instrument. He presented the result of his observations, made upon his own larynx, to the Royal Society in the year 1855, in the form of a paper entitled "Physiological Observations on the Human Voice." Coldly received at first, and regarded merely as a physiological toy, this practical application of the laws of reflected light has revealed a new horizon in the world of medicine, and, in doing so, has helped to relieve the sufferings of countless numbers of our fellow-creatures.

It is an additional gratification to us, who are about to pay homage to this venerable master, as doubtless it is also to him, to know that he has lived to see the value of his invention to medical science. It is almost as difficult for the laryngologist of the present day to realise that there was any possibility of acquiring a knowledge of the diseases of the larynx before the invention of the laryngoscope as it must be for the modern physician to imagine how his work could have been done without the aid of a stethoscope. We are, indeed, much more favoured than the men of former days in so many ways that there is small excuse if our work is not careful and accurate. The value of the habit of accurate observation was once before so delightfully illustrated by Dr. Milligan in the course of a Presidential Address from this chair that it is needless to dwell upon it again. It is a faculty for which the practice of our profession forms an excellent school. Hence, the literature of medicine, including that of our specialty, abounds in full and accurate records of observations. But, besides this, the part played by reason in the advancement of knowledge needs to be recognised. Records of facts alone do not constitute a science; it is necessary to bring to bear upon them the methods of inductive reasoning. For knowledge consists of conclusions drawn by reason from the consideration of facts. Thus, on the one hand, reason is applied to facts in order to build up the principles of medicine; and,

(a) Presidential Address delivered before the British Laryngological, Rhinological and Otological Association, January 13th, 1906.

on the other, the use of both inductive and deductive logic is indispensable in the practice of the healing art. The exercise of reason being intuitive, it is used by all from the very cradle, and upon every circumstance of life. But the uncultivated intuitive sense, without the aid of rules, is not always able to distinguish sound reasoning from false; it is, therefore, very liable to lead to error, even in ordinary matters.

Still less can it be trusted for dealing with serious scientific subjects. In medical science especially, where the data are so few in comparison with the unknown and often unsuspected factors, the issues are too important for it to be safe to form general conclusions without the greatest circumspection. Yet, in practice, it is often necessary to be provided with provisional hypotheses, where better-established theories are wanting. Accordingly, we find ourselves constantly devising working hypotheses, and reasoning from them by deduction. Provided they are based upon recorded facts, and are recognised as provisional, there is nothing to be said against their use. They are, indeed, the merchant-vessels of knowledge. Some, enduring the test of experience, gradually become accepted by the profession. Others disappear and give place to new and better ones; but a few of the wrecks of bygone theories still float about, like derelicts on the ocean, which are dangerous to navigation and very difficult to dispose of.

A mere conjecture—that is, a hypothetical proposition unsupported by actual facts—is never worth much, even when uttered by an authority, and may become dangerous by repetition. Dogma has no place in scientific medicine. Reasoning by analogy, too, is hardly ever very safe, although so commonly employed. When two things are alike in very many characters, it is probable, but not certain, that they are similar in some other respect. But when the analogous characteristics are only few, it is impossible to draw a conclusion with regard to the rest.

For the right use of reason, accuracy in the use of terms is demanded, which should not be ambiguous nor too greatly multiplied. Care should be taken to separate fact and theory; and in recording facts to keep the mind absolutely impartial, for there is a curious tendency to ignore observations which do not fit in with preconceived notions. For this reason, too, the observations of facts should be verified more than once. The application of general principles to individual instances always requires care. The teaching, at one time fashionable, that a conclusion could be reached at a glance is, no doubt, obsolete; but there is still sometimes an inclination to lean too heavily on one fact, instead of basing the judgment upon the sum of all.

It is not altogether surprising that the mediæval universities came to regard logic as the essence of learning instead of, as we know, the means to an end. The process of inductive reason is the only safe path by which to arrive at truth. There is no royal road. It is slow, because the collection of so many observations needs time. It is difficult on account of the care needed for making observations and records; and because of the necessity for the elimination of all bias. But it is the one way in which all great discoveries in science have been made. In the immortal work of Charles Darwin it is hard to say which is the

most admirable, the patience with which he had collected his enormous array of facts, the wonderful manner in which he was able to handle them, or the sublime grandeur of his conclusions. There is, indeed, nothing which gives such a sense of satisfaction to the intellect as a well-reasoned argument. The mind is led on, step by step, from one point to another, until at length it rests content upon some incontestable verity.

The subject of reason in relation to our scientific work would be incomplete without a reference to literary composition, with which it is so closely related. Writing is the chief method of disseminating reasoned thought. Not only is a clear literary style the mark of accurate perception, but the effort at clearness of expression tends to develop precision and accuracy of ideas. "Reading," says Lord Bacon, "maketh a full man; conference a ready man, and writing an exact man."

But the perspicuous writer upon medical subjects reaps other advantages. His meaning being clearly expressed, his writings are pleasant to read and easily understood; and therefore more likely to be read. Even the briefest record of a case gains immensely in value by being clothed in suitable language. Apart from the value of the subject-matter, well-written works tend to live, and they shed an additional lustre on the names of their authors. What grace and charm are to be found in the writings of Sir Morell Mackenzie, of Sir James Paget, and in those old "Lectures on the Principles and Practice of Physic," written in 1843 by Sir Thomas Watson, which may still be read with enjoyment and advantage.

The object of this Association, stated in our Constitution, is "the advancement and diffusion of knowledge in all that relates to diseases of the throat, nose and ear." We are not merely students, but professedly teachers of these subjects. We teach, in the first place, by learning ourselves. Besides this, some of us are actually called upon to impart what we know to students in the course of hospital work. It is our bounden duty, therefore, to test and retest the truth of our beliefs before imparting them to others. Accurate and unbiassed observation must be wedded to sound reason.

THE MILK SUPPLY OF EDINBURGH: WITH SUGGESTIONS FOR ITS MORE STRINGENT CONTROL. (a)

By AITCHESON ROBERTSON, M.D. Edin.

THE importance of a proper dietary during infancy and childhood is immeasurably greater than at any other age-period. Without discussing the pathogenesis of infantile disease, one may yet inquire why so many young children suffer from tuberculosis. The organism cannot enter through a healthy intestinal mucous membrane, and probably the most common cause of loss of resistance is the enfeeblement of the mucosa from the ingestion of milk which is commencing to putrefy. Of the many organisms common in milk, the most abundant are those which cause the lactic acid fermentation; hence "souring" is the first easily recognisable sign of putrefaction. Fresh milk from pasture-fed cows is faintly alkaline, that from stall-fed cattle often acid from the presence of the lactic acid organisms in the

(a) Read before the Edinburgh Medico-Chirurgical Society, January 18th, 1905.

teats or milk pails. In any case the lactic acid fermentation commences in this milk very rapidly indeed. This early acidity of milk is readily estimated, and may be taken as a standard of the freshness or staleness of the fluid. In samples of fresh new milk got from thirty-one shops the acidity varied from .112 per cent. of lactic acid to .3 per cent. When lactic acid is present to the extent of .2 per cent. the milk has a sour taste; at .25 per cent. it is unfit for consumption as a food. In more than half the shops (these were in the poor quarters, and the samples taken during warm weather) the milk had reached such a stage of putrefaction as to preclude its use as an infant's food. Such milk as this would certainly produce diarrhoea, though not necessarily the fatal type of epidemic summer diarrhoea, which is probably due to an organism of the colon group, and results from specially virulent milk pollution, in which the determination of the acidity is no use as an index of the degree to which it has proceeded. The intercommunicability of human and bovine tuberculosis must be regarded as proved. With care, no tubercle organisms should get into the milk, but with the present want of care one cow might easily infect the whole dairy supply. The percentage of samples in which tubercle bacilli have been found is very variable—3.7 in Manchester, 22 in London, 28 in Liverpool, 30.40 in Paris, and once in Cambridge as high as 56.2. It must at least be conceded that tuberculous infection of milk is not infrequent, and it seems that such milk is peculiarly liable to act prejudicially on children debilitated from diarrhoea. The immense advantage of breast-feeding is nowhere more evident than in this connection. The reason why tuberculosis is so common in dairy cows is the unhygienic state of the byres. No other article of food is prepared under such insanitary and filthy conditions as milk, and it is the only article of diet which is partaken of raw. There are still many cowsheds in the centre of the town—115, licensed to contain 3,417 cows. Many of these are hidden behind tenements, in lanes or alleys, the cows are never allowed out so long as they continue to give milk in paying quantity, and as it seems proved that a cow gives more milk when kept in a warm, confined atmosphere than when allowed into the open, there is no difficulty in seeing the inducement afforded to prolong the present state of matters. In one instance, extreme, it is true, a cow had gone on yielding milk for six years. The cubic space, even when sufficient to satisfy the requirements of the Act, is in most cases insufficient, as all sorts of expedients, such as opening connections between lofts and byres, are adopted to include in the space estimated air which is not available for respiration, which is stagnant, and which may even be positively bad, by coming from a reservoir of foul air. By the Act of 1866 a minimum of 800 cubic feet is required for each animal, except in the case of byres existing before that date, in which the amount is fixed at 600. Few of the present cowsheds have been built since the passing of the Act. The legal minimum is fixed far too low; not less than 1,000 cubic feet, and that distributed over a proper floor space, should be allowed. In most sheds at present only twenty-eight square feet is allowed for each animal. Ventilation is almost entirely neglected in these city cowsheds. On the basis of computation generally

used for estimating the air required in human habitations, it is found that each cow ought to get between 9,000 and 10,000 cubic feet of air per hour. Dr. Robertson has frequently tested the inlets and outlets with the anemometer, and found the results highly unsatisfactory. The usual method of ventilating is to have as outlets ridge openings in the roof, and as inlets perforated bricks at a height of nine feet from the floor. Such an arrangement, of course, does not ventilate the byres at all. The cowkeeper, too, has a horror of ventilation, which, he affirms, diminishes the yield of milk and causes the animals to take chills. The extreme prevalence of tuberculosis in dairy-fed cattle is due to these factors: overcrowding, absolutely inadequate ventilation, and want of sunlight and exercise. The disease occurs in from 20 to 40 per cent. of such animals, though comparatively rarely in the form of tuberculous mastitis, which occurs in only from 2 to 4.8 per cent. It is not true that only milk from a tuberculous udder contains the germs; it may contain them if the cow has any form of tuberculous disease. The increase of tuberculosis among cows during the past few decades has corresponded with the growth of the custom of keeping the animals confined in byres so as to increase their milk supply. The facility with which the disease spreads under these circumstances may readily be understood when we remember how careless and imperfect are the means employed of cleansing the byre of manure, urine, and so on, in both of which, and in expectoration on the walls of the stall, tubercle bacilli have often been detected. It should be noted that it is not until the disease has reached an advanced stage that emaciation takes place. Apart from the condition of the animals, the method by which the milk is collected is utterly insanitary. Absence of any attempt to groom the cows, or to remove the hardened faeces which encrust their flanks, absence of any facilities for the milkers cleansing their hands or wearing clean overalls, and, finally, the fact that on the same employé devolves the duty of cleansing the byre as well as milking the kine. These considerations lead one to be surprised, not at the filth the milk contains, but at the fact that it does not contain more. The only treatment to which the milk is subjected is to pass it through a wire gauze sieve, which keeps back the larger particles of solid impurity. Another highly insanitary feature of most city byres is the accumulation of manure only a few yards from the byres. It is not compulsory to remove this oftener than once a fortnight. No doubt the remedy for this state of matters is to have the dairies in the country so that the cows can live healthy lives. It is quite fallacious to imagine that it is an advantage to get the milk from a byre in the city, on the ground that the milk so obtained is freer from organisms on account of the less time which elapses before it reaches the consumer. The growth of organisms can be completely inhibited by refrigeration, but even this elementary means of preserving milk is quite in abeyance in the city byres of Edinburgh. The number of organisms in 1 c.c. of freshly-drawn milk from these byres varies from 50,000 up to millions; in a well-conducted country dairy farm it should not have more than from 5,000 to 30,000, the latter being the maximum standard for certified milk in New York. The only remedy for this state of matters is the

municipal control of the milk supply, through regulations somewhat after the following:—(1) Abolition of cowsheds within city boundaries; (2) dairy farms should all be situated in the country; (3) careful veterinary inspection to secure healthy cows; (4) application of tuberculin test every six months; (5) pasture-feeding as far as possible, when artificial foodstuffs need to be carefully selected; (6) cows to be kept in the open air except during the most inclement weather; (7) 1,000 to 1,200 cubic feet of air for each animal in the sheds; (8) thorough ventilation, allowing 8,000 to 10,000 cubic feet of air an hour per head; (9) attention to lighting and drainage of shed; (10) removal of manure frequently in the day to a considerable distance from the byre; (11) careful daily grooming and washing of the cows; (12) waterproof covering with hole for udder put on cow before milking; (13) abundant supply of water and proper washing facilities at cowshed; (14) cleansing of hands, udder and teats before milking; (15) milkers to wear overalls, and not to have to do with cleansing the byres; (16) "fore-milk" to be rejected; (17) milk to be received into a covered pan through a funnel opening; (18) milk from each cow to be strained and refrigerated; (19) milk-cans, &c., to be sterilised by boiling; (20) vessels to have locked lids—small cans should be used for each customer, or the milk measured out by a stopcock so as to avoid dippers, pouring milk from one vessel to another, &c.; (21) frequent medical inspection of workers, veterinary inspection of the cows, and bacteriological examination of the milk. These are not counsels of perfection, but obtain in all well-managed dairies. Unfortunately the number of these is too small, and the only way in which there seems any prospect of their coming into general use is by the controlling action of municipal and other local authorities. Until a pure milk supply is obtained the duty of practitioners is: (1) To insist on maternal nursing, wherever possible—donations of money to nursing mothers have been found useful in France, and the "Gouttes de Lait" have also done good in this way, but it is doubtful whether these would suit English custom; (2) the most ready means of dealing with milk so as to render it innocuous is by Pasteurisation or sterilisation, and as Pasteurisation at home is out of the question among the very poor, the establishment of milk depôts for its sale is required.

Within ten years the death-rate of children under three years in New York has fallen by one-half on account of the more extended use of pure milk. It is doubtful whether the absolute prohibition of the use of preservatives, such as boric acid or formalin, is beneficial to the community. Just because they are forbidden they are likely to be added without due care. Formalin in the proportion of 1 to 30,000 is an effectual preservative and is absolutely harmless. In conclusion, the speaker urged the formation of a medical committee to consider the question of the Edinburgh milk supply.

NASAL OBSTRUCTION AND MOUTH-BREATHING.

By J. SIM WALLACE, D.Sc., M.D., L.D.S.

WE who are concerned with the health of the community must look with satisfaction on the progress

which has been made in hygiene and sanitation, for these sciences guard the avenues leading to physical well-being. So, too, we must look with satisfaction on the progress of medicine, and the decrease and eradication of many diseases. So, again, we cannot but be gratified by the general advance of science, which in its application has led to an enormous increase in the production of the necessaries of life, and has even allowed what once were considered luxuries to come within the easy reach of all thrifty members of the community. Lastly, we must feel much satisfaction in the diffusion of knowledge relating to the laws of health to an extent which could hardly have been dreamt of by the medical practitioner of half a century ago. On the other hand, it must cause us disappointment and chagrin when we think of the alarming increase of certain diseases which we are as yet unable to control or prevent. It is one of these troubles which is rapidly becoming more prevalent that we have met to-day to discuss. Nasal obstruction is now quite a common disease, although but a few generations ago it was practically unknown. This can be easily proved, because nasal obstruction and mouth-breathing give rise to a characteristic deformity of the jaws, and to an easily recognisable irregularity of the teeth. The mouth-breather's jaw is absent in all but recent collections of skulls. Even in the Hythe collection, which is probably only a few hundred years old, there is, I understand, not a single example to betray the existence of mouth-breathing at that time.

When we recognise these facts, we naturally ask, What change has taken place which will account for the increased prevalence of nasal obstruction and mouth-breathing? One would naturally suppose that in all probability the artificial warming and imperfect ventilation of houses might be the chief change and initial cause. The sudden changes in temperature to which the nasal mucous membrane is subjected on passing from a heated room to the cold outer air can hardly be otherwise than prejudicial, nor can a stuffy and germ-laden atmosphere be considered conducive to the health of the nasal passages.

Dr. Scanes Spicer holds this view and says: "In this way the nasal mucous membrane gets into a state of inferior vitality and irritable weakness, and erects, inflames and hypertrophies. . . The secretions of the disordered mucous membrane become abnormal and irritate the lymphoid channels and follicles in the naso-pharynx, and adenoid vegetations are the result." That these conditions tend to give rise to morbid conditions of the nose and naso-pharynx is, I believe, generally acknowledged, but that they do not supply a complete explanation of the prevalence of nasal obstruction and mouth-breathing is equally generally recognised.

Another condition, possibly of greater importance, is an interference with the perspiratory function of the nose. The nose is not only a respiratory organ, for it has a perspiratory function also. If we consider what happens when we breathe, we observe that a large amount of air which is drawn into the air passages never reaches the air cells of the lungs at all, but is broken up, forming eddies over the various moist projections and recesses of the nasal cavities. The air which ultimately does reach the lungs gets moistened, of course, but so does that greater amount which is exhaled without ever reaching the lungs at all. When we are at rest in bed and well covered, perhaps too well covered, it is obvious that the general surface of the body is not so well adapted for the perspiratory function as when we are up and moving about, with the air circulating more or less freely around us. In fact, when we are lying at rest the only parts of the body over which a current of air is freely passing are the walls of the nasal cavities and the respiratory passages. It is thus perfectly natural that if we get warm in bed the nasal mucous membrane will get congested, just as the surface of the body gets congested when we become over-heated. If the nasal passages were not unduly narrow, only good would result, for the evaporation caused by the current of air through the nose would help to keep the body temperature normal and prevent

undue perspiration elsewhere. I need not refer to the harmful effects of an undue rise of bodily temperature, or to an undue amount of perspiration at night. What it is of special importance to note is, that the nose is a perspiratory organ, and if the function of perspiration is interfered with, various deleterious results are certain to be brought about. Many known facts seem to corroborate this hypothesis; for example, the fact that nasal obstruction is commonest in damp localities—i.e., localities in which the perspiratory function is carried on under more disadvantageous conditions than when the atmosphere is dry. So, too, the fact that children who are "coddled"—i.e., who are kept too warm, often in a close atmosphere, and in general placed in conditions which tax unduly the perspiratory function, are highly susceptible to colds and nasal obstruction. Then, again, we recognise that in the treatment of these troubles a moderate covering of flannel which will keep the child warm without inducing undue perspiration is beneficial.

Another concomitant of civilisation which plays an important part in inducing nasal obstruction is the unsuitable nature of the food upon which children now subsist. Any great change in the habits or in the environment to which man has, through countless generations, become adapted is almost certain to bring about some harmful results, and that an extraordinary change has come over the food and feeding of children is undeniable. Thus, for example, before cows were kept it is obvious that milk was unknown to children after they were weaned, say between the age of one year and two years, nor were the proprietary foods which imitate milk available for children. Nor was bread, nor porridge, nor milk pudding available, so that the staple articles of the modern child's diet were utterly unknown to the children of primitive man and all his progenitors.

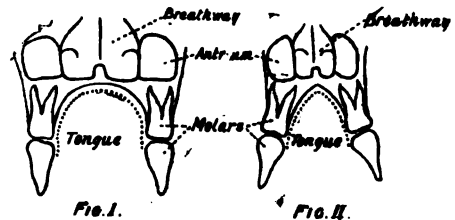
Those who know of nothing but the orthodox milk diet for young children find it almost impossible to imagine how the children of primitive man could possibly have been reared on the natural foods at the disposal of the untutored or un-Chavassed mother.

In order to indicate the magnitude of the change in feeding to which children are subjected, I shall first briefly indicate the kind of diet which the children of our ancestors were able to thrive upon. After the mother's milk began to fail in quantity and quality, and the child had erupted two sharp little incisor teeth, the child had, I believe, to supplement the decreasing milk supply by using its teeth to pierce the succulent and more or less nutritious roots, shoots and fruits which had been procured for it to gnaw and suck. This, together with some little animal food, probably gnawed and sucked from a bone, had to serve in increasing quantity for the decreasing supply of milk until about the thirteenth month, when the first molar teeth appeared and allowed some food also to be actually ground or masticated. After this age was past, the sucking process became gradually abandoned, while mastication became more thorough, until the primitive child became able to eat all and sundry with his parents. Here, be it observed, the carbohydrates, consumed after laborious gnawing and sucking, were unlikely to give rise to indigestion. They were diluted and much too thoroughly insalivated to escape without conversion or preparation for the stomach. Nor were the salivary glands denied their natural stimulus for full and healthy development. If we consider the natural period of lactation, the time of eruption of the gnawing incisor teeth and of the masticating teeth, together with the time of appearance of ptyalin and the natural stimulus for its secretion, we see that the prehistoric child was well adapted for its primitive surroundings, instinctively, anatomically and physiologically. Compare this with the recognised ordinary methods of feeding at the present day and we find that the foods are in but few ways suited for the anatomical, physiological, or instinctive peculiarities of the child. Instead of being gradually weaned and given food which will demand gnawing, sucking and insalivation, it is cheated into gulping down concen-

trated carbohydrate food such as bread soaked in milk, porridge and milk, milk puddings, and potatoes and gravy. It seldom gets the chance of learning to separate the liquid part which is fit for swallowing and leaving or rejecting the innutritious fibre which so often accompanies natural foods. Nor does it get the chance of learning to masticate its food in such a way that the fluid and finely comminuted part is swallowed first, while the less finely ground part which requires further mastication is thrown back on to the teeth again and again until it, too, is finely ground and thoroughly insalivated. In a similar way, the physical homogeneity of the soft milk-soaked diet prevents the stomach from acquiring the habit of allowing the digested part of the food to pass on through the pylorus, while it forces back the insufficiently digested part into the body of the stomach to be more thoroughly digested. But to cut a long story short, the modern child frequently, perhaps usually, falls into a state of chronic indigestion, and three of the consequences which usually follow must be mentioned, as they tend to bring on nasal obstruction. The first consequence of chronic indigestion to which I would refer is a correlated disturbance in the neighbourhood of the naso-pharynx. We know of the flabby state of the tongue and the red and swollen papillæ and sides towards its root. We are aware that even in adults, who are not so subject to inflammatory swellings as children, that "enlargement of the tonsils is not infrequently present in cases of gastric insufficiency," and this is especially so "when occurring in children near puberty" (Sidney Martin, "Diseases of the Stomach"). Finally, that the pharynx is red and congested in many cases of gastric disturbance is recognised by those who have specially directed their attention to this subject. Is it then, a great difficulty to suppose that the pharyngeal tonsil undergoes a similar enlargement to the faucial tonsil? Is it not the case that hypertrophy of the faucial tonsils is presumptive evidence of the enlargement of the pharyngeal tonsil? I need not mention the effect which this enlargement of the pharyngeal tonsil has in predisposing to mouth-breathing, and possibly also to colds, scarlet fever and measles, which in themselves are by no means without suspicion in causing adenoid vegetations.

Chronic dyspepsia with concomitant malnutrition may predispose to nasal obstruction in another way. It would appear to derange the perspiratory function and bring on attacks of perspiration from trivial causes. It is perhaps partly on account of this that the idea of an association between rheumatism and adenoids has arisen, for the disturbance of perspiration, together with cold and damp, is, as we have seen, likely to predispose to adenoids as it does to rheumatism.

Lastly, indigestion may predispose to nasal obstruction and mouth-breathing by the emaciation and



Diagrammatic representation of a section of the mouth and nose to illustrate the palate and position of the teeth when: (1) the tongue has been normal; and (2) when the tongue has been small or emaciated during the development of the palate.

general lack of strength to which it gives rise. How his comes about must here engage our attention. We know that the growth and development of the maxillæ are intimately associated with the growth and

development of the tongue. The general truth of this contention has now been so fully corroborated by the elaborate investigation and careful measurements of Dr. Grevers, of Amsterdam, that I do not feel called upon to recapitulate the evidence which originally led me to recognise this truth. All I need here say is, that a normal or unemaciated tongue stimulates the growth in breadth of the maxillæ and brings about a broad palate.

But just as the palate is made broad by this stimulus, so, too, is the base of the nose similarly broadened, and consequently, the part which is, *par excellence*, the respiratory part is correspondingly broadened. It is known to dentists, at least, that any mechanical force, when acting in the mouth more or less continuously, will expand the dental arches, and if the tongue grows as it ought, it must necessarily press the dental arches outwards also. The suture between the maxillæ allows of the deposition of bone and consequent separation of the bodies of the maxillary bones provided that there is something to stimulate such growth. What could be more natural than that the developing tongue should be the normal stimulus? On the other hand, it is only natural that if the tongue is emaciated, so, too, will the palate lack breadth.

The growth in breadth of the palate is also stimulated by efficient mastication. For with efficient mastication there comes a corresponding wearing of the cusps, especially of the temporary teeth, and a consequent loss in depth of the mouth which is compensated for by a corresponding increase in breadth. If the tongue is compressed from above downwards, the lateral expansion is correspondingly increased. Again, efficient mastication stimulates the growth in breadth of the palate by the fact that it supplies an intermittent strain on the sutures, especially through the more or less transverse action of the external pterygoid muscles. We thus see that emaciation of the tongue, inefficient mastication, and the lack of wear of the teeth brought about by the soft food given to children all tend to produce a narrow palate, narrow jaws, and corresponding lack of breadth of the nasal passages. From similar causes the naso-pharynx not only lacks breadth, but also depth from before back, for an inefficiently developed tongue does not cause that normal forward translation of the maxillæ which a fully developed tongue does; and the lack of the intermittent pressure and strain normally produced, especially by the action of the external pterygoids during efficient mastication, gives rise to a corresponding lessening of the natural stimulation to the deposition of bone between the various sutures which run transversely between the basi-occipital and the maxillæ. Now, in narrow nasal passages and a constricted naso-pharynx we have a strong predisposition to nasal obstruction, and when mouth-breathing is once commenced the chances of spontaneous recovery are almost *nil*, for nasal obstruction itself arrests the further development of the nasal cavities, as has been experimentally proved by von Ziem. Furthermore, nasal obstruction induces mouth-breathing, and this removes the normal pressure of the tongue from the maxillary alveolus on either side so that still further is the natural stimulus for the natural broadening of the palate, and consequently the nasal breathway, removed.

I might here allude to Dr. Harry Campbell's ideas with regard to the beneficent action of efficient mastication in stimulating the flow of lymph and blood, and thus establishing a healthier state of the neighbouring tissues; but I presume you are all well acquainted with his views on these and correlated subjects, (a) and will only say that if his contentions are correct they would help to enforce one of my main arguments—*viz*, that soft foods are responsible for a large amount of indigestion, and indirectly for adenoids among children.

Another cause of imperfect broadening of the nasal passages is the upright posture associated with pro-

longed ill-health and malnutrition. When the health is continuously below par the vigorous tonicity of the muscles is lessened, and instead of the thorax being held up in the manner which is characteristic of robust health, it falls somewhat, and an attitude such as that caused by exhaustion becomes almost chronic. But the fall of the thorax and viscera naturally drags hyoid, tongue and jaw downwards from the palate, thus removing the natural stimulus for broadening it, while at the same time the mouth is actually pulled open.

It frequently happens that the nose is specially congested at night, while but little blocking is observable by day. The congestion by night causes mouth-breathing by obstruction, while the conditions just referred to predispose to mouth-breathing by day. If the child were in vigorous health, the mouth-breathing by day would not take place, and the pathological condition in the naso-pharynx would have a much better chance of recovery. Thus, then, delicate health from indigestion or any other cause not necessitating the horizontal position tends mechanically and otherwise to induce mouth-breathing and concomitant abnormal conditions.

Another condition to which we must just allude is an imperfect development of the lower jaw, where the ramus joins the body. When mastication is vigorously performed the mandible develops fully in the neighbourhood of the angle, and thus a square and broad jaw is brought about; whereas, when mastication is insufficiently carried on the angle remains more obtuse. This obtuseness of the angle of the mandible, however, has an effect on the arrangement of the teeth, for it tends to make the molars meet or occlude before the rest of the teeth. In other words, the mouth is prevented from closing. It is necessarily held open. Other effects follow. The upper molar teeth are forced forward and may either become very irregular, or the incisors may be forced to protrude, and the typical mouth-breathing jaw be foreshadowed. The teeth towards the front of the mouth rise as it were in their sockets till they meet, but it frequently happens that the alveolus is so much deepened that the lips do not close without a special effort, and at least an approximation to the adenoid type of face is closely simulated. From a consideration of these facts it will be seen that the imperfect broadening of the palate associated with mouth-breathing is, or may be, brought about independently of nasal obstruction, and may ante-date it. The stenosis may give rise to obstruction with but little hypertrophy of the lymphoid or other tissue which is so liable to hypertrophy, (a)

In conclusion, it should be noted that if the general truth of my contentions be admitted, then two important corollaries naturally follow. The first is, that "the cure of mouth-breathing should be carried out by the rhinologist *pari passu* with the treatment of the teeth and palate at the hands of the dental surgeon." I give this corollary in the words of a distinguished rhinologist, for his words cannot be supposed to be biased in the way in which mine might be. In the treatment of the irregularities of the teeth we dental surgeons recognise the important help to be derived from the laryngologist in the restoration of the functions of the nose, but I doubt if all rhinologists recognise that some benefit might accrue from the expansion of the palate by the dental surgeon, and by the restoration of the means of efficient mastication.

The second and more important corollary is that we should enter a most vigorous protest against the iniquitous and ubiquitous system of feeding children almost entirely on soft milk-soaked foods. Not because milk is occasionally the bearer of tubercle, scarlet fever, diphtheria, &c., nor because it leads to constipation, fermentation and summer diarrhoea, but because this pap system is the insidious cause of

(a) "Influence of Mastication on the Jaws." "Trans. Odontological Soc.," 1902, p. 102 and 120; also "Observations on Mastication." *Lancet*, July 11th, 18th, 25th, and August 8th, 1903.

(a) A full account of many of the structural alterations caused by mouth-breathing will be found in the author's work on "The Irregularities of the Teeth, with Special Reference to a Theory of Causation and the Principles of Prevention and Treatment."

lifelong suffering from the numerous derangements of the alimentary canal which it brings on. It begins by producing the wholesale ruin of the teeth, together with many consequent troubles. It leads to adenoids and all the unfortunate sequelæ with which you are so familiar. Finally, it almost necessarily begets gastric insufficiency, mal-assimilation, and malnutrition, together with the general wreck of physical well-being which these derangements ultimately produce.

Clinical Records.

CENTRAL LONDON THROAT HOSPITAL.

Case of Lympho-Sarcoma of the Frontal Sinuses.

By DR. P. H. ABERCROMBIE.

With Microscopic Report by DR. WYATT WINGRAVE.

E. D., æt. 75, a widow, attended my clinique at the Central London Throat, Nose, and Ear Hospital, on October 22nd last, complaining of a swelling over the root of the nose, which she first noticed about a month previously. No symptoms of any kind were present, and examination of the nasal fossæ revealed nothing abnormal.

The patient knew of no cause for the swelling, although, after questioning, she remembered having had a blow on the nose "many years ago."

The swelling, which was roundish in form and about half an inch in diameter, was situated in the middle line at the root of the nose. The skin over it was normal in appearance and was not adherent to the growth, which latter, however, was fixed to the bone underneath it. Transillumination showed the swelling to be distinctly translucent, and when it was palpated, the sensation experienced was one of fluid under pressure. Both frontal sinuses were clear. Under the impression that it was a cyst of some kind, I punctured it with a trocar and cannula, but nothing escaped.

I then advised the patient to come into the hospital for operation, but this she postponed until November 18th, nearly a month later, when I operated.

The swelling in the meantime had increased in size to almost double its former dimensions, had become lobulated on its left side, and was no longer translucent. Still, there were no symptoms to speak of. The unsightliness of the swelling was what she complained of.

Under chloroform, an incision was made in the middle line over the growth, and the latter proved to be solid, though soft in consistence, of a grey colour, and attached to the bone. On removing the mass, a perforation was found in the bone communicating with the frontal sinuses, both of which cavities (the right being much the larger) were full of a similar-looking growth, together with polypoid degeneration of the mucous membrane.

There was a slight mesial ridge on the floor and posterior wall of this bony cavity, representing the position of the septum. This large frontal sinus cavity was full of the growth, but was not distended by it, and its bony walls appeared to be normal except anteriorly, where the perforation above mentioned existed. There was no pus present. The whole space was very carefully and thoroughly curetted; every trace of growth, apparently, being removed.

The cavity was packed with double cyanide ribbon gauze and dressings applied. The patient since the operation has done remarkably well, and the wound is now almost healed.

Dr. Wyatt Wingrave has very kindly made a thorough examination of the growth removed, and he regards it to be of the nature of lympho-sarcoma. He himself will read his report in full.

Dr. Wingrave tells me that the structure of this growth closely resembles that removed by me from the frontal sinus of a patient early in 1902; but in this case there was pus in the sinus as well as growth. This patient was shown by me at the May meeting of this Association in 1902, and the chief point of interest in the case was that the attacks of severe pain and tenderness from which he suffered repeatedly were

felt by him over the healthy sinus, and not at all over the region of the diseased one!

Dr. Wyatt Wingrave's Report of Microscopical Examination.—The tissue consisted of round-cells embedded in a homogeneous matrix, containing a delicate stroma of fine white or gelatine fibres. The cells were similar to mononucleated lymphocytes, but somewhat larger and possessing more protoplasm. The nuclei were round and in places exhibited active mitosis. Vascular channels composed of a single layer of epithelioid plates were present but scanty. Reference to the Pathological Register of the Central London Throat and Ear Hospital affords evidence of similar cases in which the histological details strikingly resembled the present case. One of these cases was also under Dr. Abercrombie. The specimens were all prepared by the writer. The tissue belongs to the mesoblastic type and histologically conforms to the lympho-sarcomatous group. No bacteria were found.

ROTUNDA HOSPITAL, DUBLIN.

A Case of Chronic Epithelioma following on Hydatiform Mole—Hysterectomy.

By E. HASTINGS TWEEDY, Master.

Recorded by GIBBON FITZGIBBON,
Senior Assistant, Rotunda Hospital.

THIS case of chronic epithelioma is of particular interest, as the history is very complete, the patient being under observation from the commencement of the disease.

M. W., æt. 29, multipara, admitted to the hospital on July 14th, 1904. She believed herself ten weeks pregnant, and was suffering from a sanious discharge of four weeks' duration. The bleeding had become severe two days before admission to hospital.

On examination, the os, though slightly dilated, did not admit a finger. A diagnosis was nevertheless made of myxoma chorii from a cyst which came away, and the uterus immediately emptied with a flushing curette.

The patient left hospital well on the eighth day. On October 15th she again returned, giving the following history. Hæmorrhage had commenced a few days after leaving hospital, and had continued slight and irregular. On examination, the uterus was found enlarged, soft, retroflexed, being easily replaced. The os was patulous. On the 17th the uterus was curetted, and a small piece of myxoma chorii removed, together with a large quantity of old blood-clot. As the uterus was inclined to bleed, it was packed with gauze, which was removed the following day.

The patient remained well until the 31st, when bleeding again started, and continued slight for several days. The uterus was again curetted, more with the object of exploring the cavity. A single cyst came away, and also some soft, cheesy material was very easily removed from the fundus; whilst removing this it was noticed that the curette passed evenly over the sides of the uterus and the regions of the cornua, but that at the top of the fundus there was a small area where the curette could pass half an inch further as though it had passed through the uterine wall for the greater part of its thickness. The specimen obtained from the first curettage only showed myxoma chorii in frozen section, but when fully prepared with celloidine it showed a marked degree of malignancy. This, and the fact that there was evidence as above of some growth penetrating the uterine wall, it was decided to do hysterectomy immediately.

On November 8th, vaginal hysterectomy was performed by the Master of the Rotunda, and the subsequent examination of the uterus proved the existence of chorion epithelioma. The macroscopic examination of the uterus demonstrated the cavity to be healthy, with the exception of the fundus, where a small excavation about three-eighths of an inch wide and half an inch deep was found. This had almost perforated the uterine wall, there being nothing but thickened peritoneum remaining. The tubes and broad

ligaments were free from infection. The convalescence was uninterrupted, and the patient left hospital in excellent health four weeks after operation.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, JANUARY 29th, 1905.

TREATMENT OF CANCER.

PROFESSOR JABOULAY, of Lyons, has recommended injections of quinine for the treatment of cancer of the breast, stomach, uterus, &c., by which the general condition of the patient is improved and life prolonged.

Dr. Chabannes, of Vals-les-Bains has published a case which confirms, to a certain extent, the utility of the treatment.

A patient who underwent an operation for cancer of the breast in 1899 had a relapse on the cicatrix at the end of the same year. During the four years of the treatment there was injected 15 grains of bi-hydrochlorate of quinine in twenty drops of water, in a series of 20 injections, given as far as possible daily.

At the end of five or six injections, the tumour, which had attained the volume of a small orange, and was adherent to the subjacent osseous structure, very considerably receded, and became mobile and indolent. The ganglions in the axilla also diminished in volume, and the oedema of the hand, with the pains due to compression, disappeared. This effect always followed the first few injections, and the others were continued to maintain the improvement.

In the interval of the injections the condition of the patient remained satisfactory, but at the end of two or three months all the symptoms returned; the tumour increased in volume, the skin became bluish and, above all, the pains were very severe in the arm; at the same time, the oedema of the hand proved the progress of the nervo-vascular compression of the ganglions in the axilla.

The injections were recommenced, and so on for four years, during which time the patient had received 255 injections. At the end of this time she got discouraged and desired to go to Lyons to undergo a course of treatment by radio-therapy.

But this produced no change in her condition, and she finally succumbed.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, JANUARY 28th, 1905.

At the Society for Psychiatry and Nervous Diseases, Hr. Rosenberg showed three children, two brothers and a sister, suffering from

FRIEDREICH'S DISEASE.

The disturbance of vision in the elder boy was preceded by a febrile disease. There were cerebellar ataxy, nystagmus, and dysarthritic speech, unilateral cryptorchismus and subluxation of the lower jaw. The disease was hereditary. Sensibility, mobility, and reflexes were normal. Westphal's sign was absent, and there was no deformity of the feet. In three elder children of the family the nystagmus was present in a rudimentary form. The speaker could not say whether the spinal column or the cerebellum was affected.

Hr. Skoczynski gave an account of his

INVESTIGATION ON THE SPINAL FLUID.

He had been able to perform lumbar puncture in half of his cases without an anæsthetic. In the case of an epileptic he was able to observe the pressure apparatus during an attack. At the commencement of the attack the pressure rose about 30 to 50 cm. During the tonic stage the high pressure was maintained; during the clonic period the pressure underwent violent oscillation and fell away afterwards to the normal. It could almost be predicted when an attack would come on, *viz.*, when for some time the pressure remained below the normal. The cerebro-spinal fluid contained but little albumen, 0.2 to 1 per cent., in the form of

globulins. In paralysis, on the other hand, a considerable quantity of serum-albumen was present. The albumen was greatly increased in amount in cases of organic disease of the central nervous system. Of thirty-five cases, thirty, with undoubted paralysis, contained cell material; in one case of paralysis with an unusual clinical course, the negative result was obtained. There were no cells in one case of syphilis affecting the brain; in hydrocephalus and epilepsy only occasionally; none in alcoholic dementia and encephalitis. The fluid was centrifugated in every case. Cells were numerous in paralysis with acute symptoms. This permitted a certain diagnosis to be made in doubtful cases as was shown in these illustrative cases. Choline was a decomposition product of lecithin. Out of thirty-one cases of paralytic dementia it was present in twenty-eight. It was present in three cases of cerebro-spinal syphilis; not present in hydrocephalus and alcoholic dementia, and abundant in multiple sclerosis. It was specially abundant where there was destruction of nervous tissue. He did not believe that choline excited convulsions.

Hr. Oppenheim did not believe that lumbar puncture was an indifferent procedure.

Hr. Peritz remarked that Fuchs and Rosenfeld had counted the cells of cerebro-spinal fluid as blood corpuscles were counted; this had its advantages. Whether the substance found was choline was not certain, as platinum chloride entered into the same crystalline combination with ammonia and potassium also. Even if it was shown to be choline it was not to be always looked upon as the excitator of epilepsy, for it might happen that lecithin became converted into choline in consequence of the attack, just as in epilepsy. It might be looked upon as the product of excessive muscular action.

Hr. Remak also expressed his doubts as to lumbar puncture. He would examine the spinal fluid of corpses as to choline.

Hr. Ziehen had no fears of a careful lumbar puncture, but never more than from 5 to 10 grms. should be taken at a time.

Hr. Oppenheim remarked that when larger quantities of fluid were withdrawn in cases of arterio-sclerosis, the oscillation in the pressure might cause rupture of a vessel. He was in favour of lumbar puncture only in extreme cases when diagnosis was impossible without it.

Hr. Brodmann reminded the meeting that at the last annual meeting of the Society for Psychiatry, attention was drawn to a series of serious complications brought on by lumbar puncture.

Hr. Fraenkel advised the use of only the finest needles, to avoid after-trickling when the needle was withdrawn.

Hr. Mendel would always obtain the permission of the patient or of his friends previous to performing puncture.

Hr. Skoczynski, in reply, said he had never seen any serious complication in connection with lumbar puncture. Headache or vomiting followed at times. The symptoms that followed were not all due to the operation. He did not believe that his crystallised masses depended on ammonia. Cerebro-spinal fluid from dead bodies could not be made use of as choline also arose from decomposition.

Transactions of Societies.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

MEETING HELD THURSDAY, JANUARY 26TH, 1905.

JOHN TWEEDY, P.R.C.S., President, in the Chair.

DR. FREELAND FERGUS contributed a case of Malignant Disease of the Conjunctiva, through Dr. F. R. HILL, of Carlisle. The patient, a girl, æt. 9, was sent by Dr. Hill in November, 1903. On the lower part of the bulbar conjunctiva were some sprouting vegetations with an appearance not unlike that seen in spring catarrh. The limbus and palpebral conjunc-

tiva were unaffected. It had first been noticed six months previously. The vision was 6/9, and a portion was removed for examination. The pathological report was indefinite. Shortly after the rest was removed and the patient was sent back to Carlisle under Dr. Hill's care. The pathological reports of Professor Muir and Dr. Devereux Marshall showed the growth to be of an unusual character but probably a sarcoma, but its appearance left no doubt as to its being malignant. On March 21st, owing to its rapid extension the whole contents of the orbit were removed, and the patient was sent back on April 14th. On May 23, she was again seen, but the recurrence was so extensive that no operation was possible. The neighbouring glands were also involved, and even at this time there were cerebral symptoms. The child died in October with the tumour of enormous size. The autopsy showed extensive involvement of the brain. The growth was apparently a leuco-sarcoma.

Mr. PARSONS, who had examined the growth, said it appeared to him to be one of those rare cases when some nævoid tissue takes on malignant growth and he looked upon it as being probably an epithelial growth rather than a connective tissue one.

Mr. ARNOLD LAWSON read a paper on "The Treatment of Corneal Ulcers by Quinine." The object of the paper was to bring more prominently before the profession the great value of quinine in ulcerative affections of the cornea. Up to the present time its use in ophthalmology has been restricted to a very limited class of conjunctival and corneal affections; but the author's observations, extending over four years, showed that it is a powerful curative agent in a large variety of corneal ulcers which are not amenable to ordinary routine treatment. The sulphate of quinine dissolved carefully in just sufficient sulphuric acid to hold the salt in solution is preferable to either the hydrochloride or the acid sulphate, both of which are soluble in water; and it is recommended to be used in a 1 per cent. solution. The eye should be soaked in the solution for five minutes four or five times a day, and thoroughly irrigated daily by an undine filled with the solution is advised. It causes very little discomfort, and patients use it readily, but stronger solutions give rise to pain and have no advantage. If no manifest benefit is effected within a week it may be discontinued. The rapidity of healing under this treatment is at times remarkable, and the author has seen many formidable-looking ulcers heal by this treatment alone within a week.

Mr. CLAUD WORTH read a paper on the "Notation of Prisms." He said that when one orders a spherical or cylindrical lens one does not concern oneself with the refractive index of the glass of which it is made; one specifies that it shall have a certain definite effect upon a pencil of light, and bring it to a focus at a certain specified distance. But prisms are numbered by most opticians according to the geometrical angle, so that if one wants a prism which shall deflect a pencil of light say 4° , one has to order a prism of 8° geometrical angle. The optician then supplies a prism whose actual deflecting power is somewhere between 3° and 5° , according to the kind of glass of which it is made. It is much more convenient and accurate to number a prism according to the number of degrees which it deflects a pencil of light. Although this matter had been discussed before, yet he brought it forward in the hope that the Society would make some definite pronouncement which would be accepted by spectacle-makers in this country and much inconvenience would thus be avoided.

Dr. D. J. WOOD (Cape Town) first of all referred to a case of Detachment of the Retina, which he had recorded in Vol. 12 of the "Transactions." He then described another case which he had recently seen, which bore a strong likeness to the previous one. The patient was a bucolic Dutchman, *æt.* 35, whose right eye had been lost five years before from a perforating ulcer, and the eye had been removed. Since that time the sight of the left had been failing, but had rapidly deteriorated during the last five weeks. His vision was

P.L., and he could just see large objects moving below. The pupil was active and the tension was normal. The ophthalmoscope showed two rounded detachments meeting widening out above. The vitreous was clear and one could just see below the disc, but the striking feature was the swelling and tortuosity of the vessels, which at once recalled the former case to mind. The vessels were more than double their natural size, and were tortuous to a degree. Both arteries were constricted at frequent intervals so that the arteries looked like beads, while the veins had the appearance of strings of sausages. The constricting bands were retinal in origin and looked as if they were stitches holding the vessels down. In both cases it was difficult to follow the vessels, not only on account of the tortuosity but also because the colour of the arteries and veins was so similar. There were no recent hæmorrhages, but some patches that were seen probably represented old ones. The question is whether it is a proliferation of inflammatory material in the retina or a primary disease of the vessels. Probably serous exudation caused detachment of the retina, but it is difficult to account for the lightness of colour of the veins which was seen in both cases.

Mr. LOUIS WERNER showed a sketch of a case of Neuro-Retinitis of a severe type which occurred in one eye of a girl, *æt.* 24, who was anæmic. There was neither headache nor vomiting, the only symptom being a feeling of lassitude, &c., and for a time excessive thirst. There was no albumin present, but the sugar reaction was doubtful. The left eye failed suddenly one morning and the vision was reduced to hand movement. The field of vision was greatly contracted, but the colour perception was good. The upper part of the disc was greatly swollen, with large corkscrew-like vessels spreading out from it, while the lower part was white and atrophic but indistinct. In less than three days a perfect star of white lines appeared at the macula. Under iron the swelling disappeared in three months, and the vision improved to 6/36. The author referred to a case reported by Gowers in which retinal changes resembling those of albuminuric retinitis occurred in a chlorotic patient.

Dr. L. COLB-BAKER showed an ingenious needle-holder for use with either straight or curved needles and a modification of Clark's eye speculum.

Mr. BISHOP HARMAN showed a case in which there was congenital absence of the internal and external rectus muscles.

Mr. SECKER WALKER showed a radiograph of a case of gun-shot wound in which two shots had entered the eye at the same hole and had lodged at the back of the orbit.

ROYAL ACADEMY OF MEDICINE IN IRELAND. SECTION OF SURGERY.

MEETING HELD FRIDAY, JANUARY 13TH, 1905.

Mr. G. JAMESON JOHNSTON in the Chair.

EXHIBITS.

Mr. MAUNSELL exhibited a patient upon whom he had operated for acute cholecystitis, and subsequently for gangrenous appendicitis; also a gall-bladder removed for phlegmonous cholecystitis, and another for hydrops.

Mr. C. ARTHUR BALL exhibited—(a) Prostate removed by perineal prostatectomy; (b) Prostate and calculi removed by conservative perineal prostatectomy.

Mr. MAUNSELL read a paper entitled CHOLECYSTOTOMY FOR ACUTE CHOLECYSTITIS FOLLOWING TYPHOID FEVER.

The cholecystitis manifested itself on the 27th day after the patient's admission to Mercer's Hospital. The muco-pus removed from the gall-bladder contained a pure culture of Eberth's bacillus as proved by numerous tests. Mr. Maunsell briefly described the affections of the gall-bladder which may complicate enteric fever, and strongly advocated operative treatment, quoting cases and statistics in support of his contention.

Mr. JAMESON JOHNSTON related two cases of typhoid

fever in which complications had arisen calling for surgical intervention. In one there was necrosis of the laryngeal cartilages, and in the other there was a chronic abscess of bone, and in both typhoid bacilli were found in the pus.

Sir CHARLES BALL had seen many cases in which disease of bone had occurred many months after typhoid fever. He related a case also in which, during the acute stage of the fever, a large abscess developed in the upper lobe of the lung.

Dr. FINNY considered that the question of interest in Mr. Maunsell's case was whether the acute cholecystitis was a complication of the acute fever or a *sequela*. These complications were to be expected, not in the height of the fever, but just when the patient seemed to be getting better. He did not think typhoid bacilli were the sole cause of the complication in the present case, as they are often found in great numbers in the gall-bladder without any results, locally or otherwise, in the neighbourhood. Mr. Maunsell's patient first came under observation on account of a septic finger, and it was just possible that septic organisms were associated subsequently with the typhoid bacilli.

Mr. MAUNSELL, in reply, stated that in looking up the literature of the subject he had noted instances of complications arising fourteen and a half years after typhoid fever, and in which pure cultures of the typhoid bacillus were obtained. He had thought of the possibility of the crushed finger having had something to do with this case, but on very careful examination no septic organisms could be found.

CONSERVATIVE PERINEAL PROSTATECTOMY.

Mr. C. ARTHUR BALL introduced this subject by referring to the methods of prostatectomy as usually performed by the suprapubic or perineal route, which he considered could not be regarded as ideal surgical procedures, for the prostate had to be removed largely by the sense of touch; hæmorrhage during these operations was not fully under control; and the amount of injury inflicted on the bladder, urethra, and ejaculatory ducts was frequently considerable. He said, the question we had to decide was, Can the prostate, or rather a sufficient part of the prostate, be removed so as to cure the patient without inflicting permanent injury to important anatomical structures? Perineal prostatectomy, as performed by Dr. Young, of the Johns Hopkins Hospital, seemed to him to fulfil these conditions more fully than the methods previously advocated. He then proceeded to explain Young's operation of conservative perineal prostatectomy, illustrating the various steps of the operation by means of lantern slides, showing that the lateral and median portions of the prostate could be removed without injuring the mucous membrane of the bladder or the urethra and ejaculatory ducts, a matter of some importance now that prostatectomy is being done in younger men.

Mr. JAMESON JOHNSTON stated that he had always performed the suprapubic operation, and still thought it the right one. He did not think there were such things as lobes in enlarged prostate; the prostate was simply adenomatous, and there was no definite lobar arrangement. The ingenious idea of Lane's operation was to be admired—*viz.*, the preservation of the ejaculatory ducts.

Mr. EDWARD H. TAYLOR stated that he had had the privilege of being present at Mr. Ball's prostatectomy operations. He had previously no experience of the perineal method, but had performed the suprapubic operation, and was much impressed in its favour. It was not very difficult, but left much to be desired as one had to work largely by the sense of touch. He was impressed by the ease with which the prostate could be exposed by means of a curved incision in front of the anus, the facility with which the capsule could be peeled off the lateral lobes, and the large veins of the vesico-prostatic plexus avoided. Against the operation was the fact that it entailed an extensive dissection and division of the compressor urethra muscle. There was considerable risk, therefore, of

injuring the sphincteric apparatus of the bladder, with subsequent incontinence of urine. There was much less risk of incontinence with the suprapubic operation.

Mr. MAUNSELL thought it was a mistake to say that all cases should be done either by the suprapubic or by the perineal operation. His experience was only with the former, because in his cases the prostatic enlargement was very marked. He would not think of removing a large adenomatous prostate through the perineum, and would only employ the perineal operation for prostates of small size. The speed with which it could be performed was in favour of suprapubic prostatectomy, and this was a point of importance with elderly patients.

Mr. LENTAGNE said he had often thought that a better method than the suprapubic in prostatectomy could be devised, but he was not yet converted to the perineal route; it was much more likely to lead to septic troubles than the suprapubic, as there was much more division of tissues.

Sir THOMAS MYLES said he did not quite understand what became of the mucous membrane of the bladder which covered the upward bulging portions of the prostate. Was it torn in parts or was it removed *en bloc*? Was the ideal method to leave an intact urethra and an intact bladder? He described the method by which he had carried out the perineal operation. In his opinion, if the bladder mucous membrane covering the prostate had to be divided at all it had better be cleanly removed, otherwise a ragged surface was left and pieces of the mucous membrane might subsequently obstruct the urethra.

Mr. STONEY stated that, viewing prostatectomy from the anatomical standpoint, the best method was that which aimed at removing the prostate from within the bladder. In the perineal operation the prostatic capsule was divided and the pelvic cellular tissue was exposed to septic influences.

Mr. BALL, in reply, said he had not intended to deal with the question as to which of the two operations of prostatectomy was the better. The mortality after the perineal operation was less than half that following the suprapubic, which fact alone would tend to make one employ the perineal route. Although in many cases suprapubic prostatectomy could be done with rapidity, yet this was by no means always the case. Also, he thought drainage was better by the perineal than by the suprapubic route. In conservative perineal prostatectomy the mucous membrane of the bladder over the prostatic lobes was supposed to be left intact.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY. MEETING HELD JANUARY 18TH, 1905.

PROFESSOR JOHN CHIENE, C.B., in the Chair.

Dr. W. ALLAN JAMESON showed (1) a case of psoriasis, illustrating the effect of oxydised pyrogallic acid in the treatment; and (2) two cases of lupus healed by X-rays after a prolonged period of rest.

Dr. CHALMERS WATSON gave a microscopic demonstration on the changes induced in the thyroid gland of animals by a meat diet.

Dr. ARCHIBON ROBERTSON read a paper on "The Milk Supply of Edinburgh: with Suggestions for its more Stringent Control," which will be found fully reported on page 102 of our present issue. The paper was illustrated by a number of photographs, taken for the most part under circumstances of some little difficulty, of city byres and their surroundings. It was discussed by Drs. Melville Dunlop, H. H. Littlejohn, Robertson, and James Carmichael, and a Committee was nominated to consider the question and report to the Society.

Dr. HARRY RAINY read a paper, illustrated by a lantern demonstration, "On the Nature of Friedreich's Ataxia," which will be published in our next issue. The paper was discussed by Drs. Alexander Bruce and Chalmers Watson.

THE LARYNGOLOGICAL SOCIETY OF LONDON.
MEETING HELD JANUARY 13TH, 1905.

THE following interesting cases and specimens were shown:—

Dr. STCLAIR THOMSON exhibited a case of epithelioma in a man, *æt.* 50, in whom laryngo-fissure was performed, and there was no recurrence after six months. He also showed a boy, *æt.* 14, in whom tracheotomy was performed for extreme stenosis, the larynx being extensively ulcerated, and the cords fixed in the middle line. There was a marked improvement after the operation, and the diagnosis rested between tubercle, lupus, or congenital syphilis.

Mr. DE SANTI showed, for diagnosis, a case of swelling of the left arytaenoid region, in a woman, *æt.* 35. The diagnosis was considered to be either tubercle or malignant growth.

Dr. TILLEY showed a case of tracheal obstruction. The opinion of the members was that the case was probably syphilitic.

Sir FELIX SEMON showed two cases: (1) Pharyngeal and laryngeal nystagmus in a case of probable tumour of the pons; (2) a case of inflammatory oedema of obscure origin, affecting the posterior part of the larynx, in a man, *æt.* 45.

Dr. FITZGERALD POWELL showed a case of epithelioma of the palate, tonsil, tongue and cheek, and suggestions were invited as to the effect of X-rays in such a case. The opinion generally expressed was that X-rays would not be of much value in such cases.

Dr. WESTMACOTT showed a case of ulceration of the soft palate, which had been operated upon frequently, yet was perpetually recurring. It was not influenced by iodide of potassium.

Mr. PARKER showed a case of symmetrical enlargement of the thyroid; and a beautiful series of paintings in oil, indicating diseases of the throat and larynx, were exhibited by Dr. SMURTHWAITE.

Dr. PATERSON showed a pair of laryngeal forceps for use by the direct method.

BRITISH LARYNGOLOGICAL, RHINOLOGICAL
AND OTOLOGICAL ASSOCIATION.
GENERAL MEETING HELD FRIDAY, JANUARY 13TH, 1905.

The President, Mr. NOURSE, in the Chair.

Dr. J. SIM WALLACE read a paper on "Nasal Obstruction and Mouth-Breathing," which will be found on page 104.

Dr. WYLIE remarked that the paper was really a little too deep for them to fully discuss on that occasion. He therefore proposed that the discussion be adjourned until the next meeting, and that Dr. Wallace be asked to publish it in some well-known paper so that they could all read it, and discuss it at the next meeting of the Association.

Mr. W. STUART-LOW (Secretary) seconded the resolution, which was unanimously agreed to.

The Presidential Address was then delivered by Mr. CHICHELE NOURSE, F.R.C.S.Ed., and will be found on page 101 of the present issue.

Dr. REID moved a vote of thanks to the President for his Address.

Dr. VINRACE, in seconding the vote of thanks, said they were indebted to the President for his most scholarly and instructive Address. The President had expressed very broad and liberal views in the dissertation he had put before them. He had shown them that in any endeavour to get the supremacy over laryngeal troubles they had by no means a menial task set before them. He had also hinted that their specialty was inseparable from general work. As an old individual member of the Society, it had been his (Dr. Vinrace's) pleasure to listen to the eloquence of Sir Morell Mackenzie, and they owed that deceased gentleman a very deep debt of thanks. It was within the knowledge of most of them that in the year 1887, when Sir Morell Mackenzie founded the Society, very few took an interest in it, and such subjects as were then

discussed at the meetings were tabooed and looked upon as not requiring to be considered. But at Oxford last year there was a consecutive attendance of 150 members in the particular section which their Society represented. In the days of Sir Morell Mackenzie, in 1887, the muster was only about seven or eight.

The vote of thanks was warmly accorded.

The PRESIDENT thanked those present for the kind way in which they had received his remarks.

DISCUSSION ON THE CLINICAL CASES.

A case of Nasal Polypus with Deformity was shown by Dr. W. H. KELSON:—The patient was first operated on for polypus at the hospital when *æt.* 13. He remained apparently free for a year, when the nose again became stuffy, and finally completely blocked. When seen in September last the right side was found to be filled with polypi, and the nose a good deal broader than normal. The left side was stenosed, and contained a few polypi; there was some pus on both sides; never any hæmorrhage. The nose was thoroughly scraped out in October, but recurrence had already taken place. Sections showed the polypi to be of the common mucous variety.

Dr. WYATT WINGRAVE said the case illustrated a condition of things in which granules had been formed and became polypi. A large number of polypi had been removed, but they were not the disease, but only the symptom. The polypi, if small, manifested the myxœdematous changes in the granulous tissue.

A case of Ulceration of Palate for Diagnosis was shown by Dr. WYATT WINGRAVE in an unmarried female, *æt.* 31. She complained of pain in her throat, with discomfort in swallowing, of three months' duration, with rapid loss of flesh. On examination, a shallow ulceration was visible occupying the posterior wall of the oro-pharynx and extending downwards to the laryngo-pharynx behind the faucial pillars. There was considerable accumulation of mucus on palpation. The edge of the ulcer was found to be hard and sharply circumscribed. Beyond some slight swelling of the right arytaenoid the larynx was normal. The post-cervical glands were but slightly marked. There was no history or evidence of tubercle or syphilis. Scrapings were made of the ulcer, which showed numerous epithelial squames of normal structure, pus cells, and various bacteria, including diplococci, staphylococci, bacillus subtilis, and bac. *prob.* vulgaris. No tubercle bacilli were found in several examinations. She was placed upon iodide of potassium (*gr.* xv), and in the course of one month has gained over four pounds in weight, and can swallow comfortably. The ulcer is less hard and less extensive.

Dr. VINRACE, referring to the statement, described the case as possibly one of epithelioma, and said he thought that the fact that potassium had been given for a whole month in considerable quantities rather negatived that theory, because a patient after taking so much potassium for that length of time would, he thought, be in a much more emaciated condition than was evidenced in that case.

A case of Tertiary Syphilis of the Nose associated with Epiphora was shown by Dr. DAN MACKENZIE: Male, *æt.* 35. Primary infection 2½ years ago. Treated for one year. Present illness began with watering of eyes four months ago. Nasal stenosis observed by patient about same time, but not connected with eye trouble. Has attended ophthalmic hospitals for relief of epiphora, where the usual treatment was adopted without benefit. No notice was taken of the nasal trouble. A few weeks ago he was seen by Dr. Corner, of Forest Gate, who noted the co-existence of nasal trouble, and sent him for my opinion. On examination, on December 21st, 1904, the right inferior turbinal was found enlarged and ulcerated. On the left side an ulcer fairly well back was noticed on the floor and septum, not very deep. On the posterior pharyngeal wall were two or three fairly typical ulcers. Posterior rhinoscopy showed excoriation of posterior end of right inferior turbinal. The case is shown as demonstrating the inconvenience of keeping specialisms in "water-tight compartments."

Dr. WINGRAVE said this case very well illustrated the importance of looking at the floor of the nose. They rarely found the floor involved in tuberculous conditions, and some others, but in tertiary conditions they ought to look for indications on the hard palate and the floor of the nose.

The PRESIDENT said he considered that the case was a very interesting one as illustrating the close connection between some eye affections and the nose. It brought to his mind a case of his own which he saw some nine or ten years ago. The patient was a girl, *æt.* about 21, and she consulted him on account of laryngeal catarrh. She had an obstruction of the nose from a hypertrophic rhinitis, and also a fistula over the right lachrymal sac. There was a disfiguring mark down the face from the continual trickling of the discharge. Four years before then she had an abscess at the inner canthus of the right eye. The nasal duct was probed, but the fistula had remained ever since. He performed turbinectomy, and in three months the fistula had completely healed up. He had another case. Only a few days ago he saw a man, *æt.* 44, who consulted him on account of tertiary syphilis of the pharynx and nasal obstruction. He had had a lachrymal abscess on the right side in September, 1902, and was operated on in February, 1903. The patient demonstrated to him by pressing on the sac that there was still a discharge of muco-pus going on. On examination he found that the inferior turbinal was very large. He proceeded to remove the anterior end of the inferior turbinal, and it was possible that when drainage had been established, the condition of the lachrymal apparatus would improve. Diseases of that apparatus were undoubtedly in some cases in the domain of our specialty.

The PRESIDENT showed a case of

FRACTURE OF THE LARYNX IN A MAN, *ÆT.* 65.

On November 23rd last the patient, a labourer, *æt.* 65, fell and struck his neck against the edge of a wheelbarrow. Dr. Thomas Johnstone, of Nunhead, who then saw him, elicited crepitus quite easily, and recognising the nature of the case, sent the man to the hospital. Three days later the laryngoscopic appearances were as follows:—The left arytenoid and left ventricular band were much swelled and of a dark purple colour. The left vocal cord was thick, whitish, and oedematous, and was fixed in extreme abduction. Between it and the ventricular band a bright red tongue appeared. The right side of the larynx was nearly normal. Some discoloration was visible in the trachea. There was no breach of surface. The right vocal cord moved up to the middle line, or a little beyond, but remained flaccid, and flapped to and fro in phonation; and an interval remained between the hinder parts of the cords. Externally, some swelling could be felt in the region of the larynx, but there was no emphysema. The patient's voice was hoarse, low-pitched and weak. Deglutition was painful, but there was no dyspnoea. Two days later the laryngeal swelling had diminished, and the left vocal cord was moving. The oedema extended to the right cord, and then gradually disappeared in about six days; but the discoloration of the part was still visible until the end of December.

Dr. W. H. KELSON said they all knew that one got peculiar crackling sounds much like crepitation when moving the larynx on the anterior portion of the spine. In this case which he had examined, the patient told him that he had never brought up any blood, so that it could not be a case of fracture. He did not know that the case was anything more than contusion of the larynx, or whether there was any cicatricial material or evidence of fracture beyond those sounds of crepitation.

Dr. D. A. MACKENZIE remarked that as far as possible they should endeavour to avoid their observation being attended by bias. He understood it had been said that in such cases as they were discussing there was no possible oedema of the vocal cords. This patient towards the end of the history, when the larynx was healing up, showed two very beautiful translucent

blebs on the vocal cords. He believed that in cases of the kind there had been observed such a thing as oedema of the vocal cords.

Dr. CHARLES HAWTHORNE said he would shortly report a case which was especially interesting to laryngologists. It was that of a man, *æt.* 70, who one morning, when he was getting out of bed, fell to the ground—a matter which he regarded as comparatively trivial. He admitted striking one side of his head against a chair or some article of furniture, and got back again into bed. Shortly afterwards he was seized with coughing and brought up two teacupfuls of blood. Soon his throat began to swell, and he had some difficulty in breathing. He was taken away and admitted to a hospital and placed in the physicians' ward as a case of hæmoptysis. In the course of about twenty-four hours the swelling, which had commenced at the throat, spread practically all over the tongue, and was undoubtedly a swelling due to emphysema. Dr. Middleton, the physician in attendance, called in some of his surgical colleagues, and they thought that the case must be one of fracture, and the hæmoptysis was due to surgical emphysema. It was impossible to localise the fracture, and the condition persisted, and the man died some three or four days after admission. Here was a special laryngeal fact—an attempt was made to examine his larynx without any success; the swollen condition of the larynx prevented it. At the *post-mortem* there was found in the larynx a condition which was described as a cavity underneath one vocal cord, and the cavity exposed a necrosed cartilage. It was through this degenerated cartilage that air had entered the subcutaneous tissue. The history of that patient failed to reveal any suspicion at all on the part of Dr. Middleton or his friends that the man had any disease of the throat. But Dr. Lindsay Stephen, who made the record, described the condition as quite unlike anything which he was familiar with, such as tuberculous or syphilitic ulceration. It was suggested that the condition of the larynx had taken origin in some small foreign body which had become lodged and led to gradual ulceration and necrosis, and had afterwards disappeared. That was a case, therefore, of fracture of the larynx supervening on a condition of necrosis, and first of all revealing itself by hæmoptysis and surgical emphysema. Apart from the particular appeal which the case made to laryngologists, he thought that it illustrated very forcibly that they could not cut up the practice of medicine safely into different departments, for each one of which a particular individual made himself responsible. When they took charge of a patient it seemed to him that they took charge of a whole patient. Unless they deliberately obtained the assistance of some other person with whom the responsibility was divided, it would be no excuse, when some unfortunate condition developed, to say, "That is not a part of the body which falls under our domain."

Dr. CHARLES HEATH said that in this case of fracture of the larynx it was quite possible that the right half of the cartilage was overlapping the left, so that the fracture might not be quite in the middle.

The PRESIDENT remarked that one could still detect an external deformity in the case. The accident occurred on November 23rd, or about eight weeks ago, so that considerable repair had had time to take place. When the case first came under his notice crepitation could be distinctly elicited. Dr. Johnson, who was present among them, saw the case, and when he first saw it he found that crepitation could be quite easily elicited. Moreover, when he (the President) saw the case for the first time he discovered on examination by the laryngoscope that the left cord was not only abducted, but it did not appear to be quite in the natural position of abduction; it seemed as if towards the hinder end it was pushed further than it ought to be. He based his diagnosis upon the external deformity, upon the immobility of the cord, upon the crepitation, and also upon the tremendous extravasation in the laryngeal tissues. There was no doubt that it was a case of simple and not of compound fracture. Hence

there was no emphysema, which usually happened in compound fractures. Since he had had the case he had looked up the matter and found that the mortality in such cases was very high. Out of sixty-nine cases of fracture of the larynx quoted by Durant in his paper in "Hope's System of Surgery," there were fifty-three deaths. Thirty cases were fracture of the thyroid cartilage, of whom twenty died. Almost all cases that he had come across were compound fracture, and it seemed as if that was one of the elements which produced a very high mortality. A great many of them were the result of great violence and were attended by some other injuries. With regard to the œdema of the cords, this was very interesting. There was no doubt about the cords being very much swollen and infiltrated with fluid, particularly the left cord, which was translucent and whitish. Then towards the end of the time, shortly before the œdema and extravasation disappeared, the colour of the fluid became yellowish, as if it were tinged with blood. He was very glad to hear of the very interesting case mentioned by Dr. Hawthorne.

A case of Paralysis of the Left Vocal Cord following Operation for Adenoids, in a young woman, æt. 20, was shown by the PRESIDENT.

The operation was performed on November 8th. Fifteen days later the left vocal cord was found to be immobile in the cadaveric position. It has since gradually regained its mobility; when last seen on January 4th it was adducted during phonation, although not so perfectly as the right cord. The right arytenoid still passed in front of the left. Dr. Dan Mackenzie, who first detected the paralysis, kindly examined the chest, and found both the heart and lungs normal.

Dr. KELSON asked if there was any evidence that the cord was not paralysed before the operation?

Dr. WINGRAVE said the case was one of those where it was a question as to whether they were to associate the unilateral paralysis with the operation itself as a cause. With regard to the operation being causal, they must bear in mind that the connective tissue of both arytenoids, especially the left, was distinctly swollen. It was not at all unfamiliar to them that bilateral paralysis might occur before and after an operation. It was not at all uncommon to find some disturbances of the spinal accessory nerve in persons suffering from adenoids, particularly in infants. But it was a most unusual thing to find paralysis of the bulbar accessory when the paralysis was unilateral. He was not aware that any such case had ever been recorded.

The PRESIDENT said it was quite impossible for him to say whether the paralysis was present before the operation or not, because there was nothing which led one to examine the larynx, nor did the symptoms shown at the time direct attention to the larynx. The reason why one rather inferred that the operation was the cause of the paralysis lay in the fact that, when the paralysis was first noticed, a fortnight after the operation, on that side it was more complete than it was at the present time. As to the cause, he thought that one must wait before giving his opinion.

A case of Leukoplakia (Tongue) was shown by Dr. P. H. ABERCROMBIE.

The patient, a man, æt. 63, was sent to me by Dr. Cumming Grant, on the 6th of this month, complaining of deafness. This proved to be of the obstructive type, and in the course of the usual routine examination, the tongue condition was noticed. No complaint was made of the tongue, and it caused practically no inconvenience. The dorsum of the tongue presented a large, milk-white raised, fissured patch, which had existed for about ten or twelve years. Previous to this, the patch was red in colour. In the causation of this affection, syphilis, tobacco, indigestion, alcohol, and carious teeth are said to be factors; and in this particular case the first two, at any rate, may have been operative. He had syphilis about forty years ago, and this appears to have been inefficiently treated. Such a marked example of this disease is not common, at least among the patients of a throat hospital, and I think the case is worth showing. The fact that

malignant disease may develop in tongues thus affected necessitates careful watching of the patient. As to treatment, irritation of whatever kind should be removed; alcohol, tobacco and condiments are harmful. Anti-syphilitic treatment may be necessary. Locally, a mouthwash of borax or chlorate of potassium is sedative. Defective teeth require attention, and the diet should be regulated, if at fault. Several names have been given to the disease; thus, in addition to leukoplakia, it has been called psoriasis, ichthyosis, leukokeratosis, and chronic superficial glossitis. Perhaps the best names are leukoplakia (which is descriptive of the appearances—white patches), leukokeratosis (with reference to the changes which occur in the epithelium) and chronic superficial glossitis.

Dr. WYATT WINGRAVE mentioned, with reference to Dr. Abercrombie's case, a case which had come under his observation, and which, he said, was one of no small interest, because it was an instance of fungus. There was a large mass projecting through the substance of the skin from the anterior frontal sinus, and on examination it presented all the histological characters of lymphosarcoma, that was to say, it was composed of corpuscles and relatively large round nuclei and somewhat scanty protoplasm and a small proportion of stroma.

Specimen of Rhinolith, shown by the PRESIDENT.

This specimen, weighing sixty grains, was removed from the right nostril of a young woman, æt. 21. It was lying on the floor of the meatus beyond the vestibule, and between the septum and the anterior half of the inferior turbinal body, which it had compressed. Removal was rendered easier by the fact that there were no granulations surrounding it, as is sometimes the case. There was no fetor or discharge, and the patient had complained of no symptoms. About a month before, she had noticed something white in the nostril, which had led her to consult Dr. Hughes, of Dunstable, who removed part of the concretion, and sent her to the hospital. Rhinoliths are not, in the author's experience, of very common occurrence. This is only the fourth case met with by him during the last five years. Two of the others consisted of friable deposits of large size around a nucleus formed by a piece of coal and by a sequestrum respectively. The third case was that of a woman, æt. 53, whose right nostril was occluded by a greenish-black mass, with a smooth convex surface, which lay in the vestibule and stretched it on all sides to its fullest extent. The right side of the nose bulged externally, and the septum was pushed over towards the left. The edges of the nostril all round overlapped the edges of the concretion in such a way that it appeared like a stone in a setting, and it was impossible to dislodge it without breaking it up. On the floor and sides of the cavity where it had rested, there were a number of polypoid growths, and behind, the nostril was full of polypoid

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

The annual general meeting was held at Manchester on Friday, January 20th, Sir Wm. Sinclair vacating the Chair in favour of the newly-elected President, Dr. D. Lloyd Roberts. The following office-bearers were appointed:—Vice-Presidents: Sir William Sinclair, M.D.; W. Walter, M.D., Manchester; Owen Bowen, M.R.C.S.; Arthur J. Wallace, M.D., Liverpool; J. B. Hellier, M.D.; A. C. F. Rabagliati, M.D., Leeds; John W. Martin, M.D.; Percival E. Barber, M.R.C.S., Sheffield. Honorary Treasurer—E. Octavius Croft, M.D., Leeds. Honorary General Secretary—W. E. Fothergill, M.D., Manchester.

APOPLEXY OF THE OVARY.

Dr. HAWKINS AMBLER showed two specimens illustrating this condition. The first was from a lady, æt. 41, who had violent abdominal pain accompanying influenza two weeks after an unusually profuse menstrual period. The uterus was enlarged and emitted a sanious discharge. The left ovary was represented by a blood cyst the size of a hen's egg, a chocolate-coloured putty-like mass being enclosed in a shell of altered ovarian tissue. The right ovary was

cystic, inflamed and adherent. The second was from a patient, *æt.* 35, who had had severe menstrual pain for a year, with various attacks of pelvic peritonitis. An oval cyst was found adherent to the left side of the uterus, the colon and the rectum. It was as large as an orange, and was filled with blood clot and fibrin and represented the left ovary.

UTERINE SOUFFLE.

Dr. J. B. HELLIER described two cases illustrating the production of uterine souffle. The first was one of uterine myoma, the size of a three months' pregnancy, which produced a loud bruit and also a palpable thrill. After removal, the uterus was injected, showing the presence of a large uterine artery and large venous sinus on the right side. The second case was one of retro-peritoneal sarcoma which pushed the uterus against the abdominal wall in the hypogastric region. Over the uterus, which formed a visible prominence reaching $3\frac{1}{2}$ inches above the pubes, there was a soft souffle which disappeared after the enucleation of the tumour.

The PRESIDENT, Dr. Lloyd Roberts, showed a liver enlarged by metastatic deposits, the primary lesion being cancer of the head of the pancreas. A lobe of the liver divided from the main mass by a deep sulcus extended into the right side of the pelvis. A point in diagnosis was thus raised, as during life the condition suggested the presence of a tumour of pelvic origin co-existent with enlargement of the liver.

The Operating Theatres.

GUY'S HOSPITAL.

SEQUELA OF A PYLORECTOMY.—Mr. ARBUTHNOT LANE operated on a patient, a man, *æt.* 54, from whom he had excised a cancerous pylorus three years and four months previously. He closed the pyloric and duodenal orifices and performed a gastro-jejunostomy. The patient did very well till a month previous to his admission, when he began to complain of distension of his abdomen and a feeling of sickness; these symptoms were quite different from those produced originally by the pyloric obstruction, and there was distinct distension of the small intestine and of the large as far as the umbilicus. Above the umbilicus a hard mass could be felt. On opening the abdomen the obstruction was seen to be due to the presence of a dense cicatricial cancerous mass in the meso-transverse colon. This pulled on the colon, which was attached to the abdominal wall, and contracted its calibre very considerably. The mass with the transverse colon was removed, the ascending colon being drained and the splenic flexure closed. The stomach was perfectly healthy and functioning well. On this occasion, two weeks after the removal of the large bowel, Mr. Lane divided the ileum about six inches to the proximal side of the cæcum and established a communication by lateral anastomosis with the sigmoid flexure. Mr. Lane said there was no evidence of any secondary growth in the liver and the infection of the transverse colon was by direct extension from the cancerous gland in the mesentery.

CHRONIC ULCERATIVE COLITIS.—FISTULOUS APERTURE IN END OF ILEUM.—OPERATION TO CONNECT ILEUM WITH SIGMOID.—The same surgeon operated on a patient who a year before had suffered very severely indeed from acute ulcerative colitis. Fearing that he was dying his medical attendant picked up the end of the ileum through a hole in the right groin and drained it, so diverting the faecal matter from the large intestine. This operation, though it certainly saved the patient's life in that the symptoms were immensely relieved by it, left the patient in a condition of chronic ulcerative

colitis. When he was admitted all faeces passed through the hole in the groin, while he discharged at intervals a quantity of foul-smelling mucus from the anus, over which he had no control whatever; he was miserably thin. Mr. Lane made a hole in the left groin and explored the viscera. He found the whole of the large intestine shrunken to the thickness of a lead pencil, and of a livid colour. The sigmoid presented the same appearance, so that it was absolutely out of the question to attempt to establish any communication with it, partly on account of its minute size and partly because of the rotten state of its walls. By exerting much traction on the rectum it was found that a portion of it was sufficiently dilated to make an operation possible, and after great difficulty the ileum, after it had been cut through, was united to this piece of bowel.

Mr. Lane said that in an acute case of ulcerative colitis in which he had operated recently the bowel was so inflamed and vascular, and its walls so friable, that he was unable to connect the ileum with the sigmoid as he had intended. The course pursued in the case just operated on—namely, of establishing an aperture in the right groin through which the whole of the faecal contents escape from the ileum—is probably, he thought, the best mode of treating this condition. The large bowel may also be treated locally by flushing it very effectually through the distal portion of the ileum. Fortunately the patient did very well, and he has not only been relieved of the distress consequent on the escape of irritating material from the ileum, but he has to some extent regained control over the sphincter. His general condition is improving steadily.

NORTH-WEST LONDON HOSPITAL.

OPERATION FOR LARGE OVARIAN CYSTOMA.—Mr. JACKSON CLARKE operated on a patient, a married woman, *æt.* 43, tall and thin, with a weak voice and cough from slight chronic bronchitis. The abdomen was distended in the whole of its vertical and lateral extent. Two years before admission patient had noticed pain in the lower part of the abdomen, and for the last three months she had been aware of increasing enlargement and discomfort. She had been twice tapped, obtaining temporary relief; large quantities ("several gallons") of fluid having been drawn off. Each time the abdomen refilled rapidly. On admission, the patient looked ill; her pulse was 88, the abdomen was symmetrically enlarged and dull everywhere, save over the right flank. Percussion note was unaffected by position, and there was a marked thrill, especially in the uppermost part of the abdomen. The menses had been irregular for some time. Vaginal examination showed the uterus to be slightly less movable than usual, but there was no bulging felt. The patient complained of a good deal of pain in the rectum, where some piles were found. The usual median incision was made and the tumour was found to be adherent to the peritoneum by a broad surface. An opening gave vent to a large quantity of viscous blood-stained liquid. Successive cysts were opened and evacuated; some contained clear, others variously-coloured, liquid. The incision in the parietes was then extended upwards till a part was reached midway between the xiphoid cartilage and the sternum, where the peritoneum was not adherent; a finger was passed in and the tumour was separated from the abdominal wall and the opening in it securely tied up. Before the tumour

could be brought out through the wound very numerous adhesions to the stomach, duodenum, omentum, spleen and small and large intestines had to be clamped and divided. The pedicle was the left broad ligament, and this was secured by interlocking sutures and the tumour removed. The adhesions were then tied off and cut short, and the abdomen dried. The wound was stitched in three layers—peritoneum, aponeurosis, skin—and a good packing of cotton wool was placed under the bandages to hold the over-stretched and thinned parietes to the viscera, which now filled but a fraction of the potential space of the abdominal cavity. Mr. Clarke said that the case afforded still another instance of the close resemblance that there is, superficially between the symptoms of ascites and cysts in the abdomen.

For a week after the operation patient's cough was slightly worse, and she was restless for the first two nights. Apart from this she had no trouble. The tumour was a typical ovarian cyst-adenoma with a fair amount of solid tissue.

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“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, FEBRUARY 1, 1905.

THE METROPOLITAN SUNDAY AND KING EDWARD'S FUNDS AND THE SMALL HOSPITALS.

IN our last issue we laid certain considerations before our readers with regard to the Western Skin Hospital, to which no grants have been awarded by either the Metropolitan Sunday or the King Edward's Funds. We showed that it was one of the oldest special hospitals in the United Kingdom; that during its long career its affairs had been administered with the most vigilant and unceasing economy; that its absolute integrity and honour had never been once called in question, and were, moreover, vouched for by the names of those answerable for its administration, such as, for instance, that of the present Honorary Treasurer, the Hon. Harry Lawson, M.P. In spite of these conditions the Western Skin Hospital is subjected year after year to the injurious humiliation of being excluded from the grants of two out of the three Metro-

politan hospital funds. We had hoped that Sir Henry Burdett, who in the pages of the *Hospital* has made some show of answering our criticisms on the administration of the Sunday and the King Edward's Funds, would have furnished a clue to the mystery. Our hopes have been doomed to disappointment: even his previous plan of pointing out minor errors of detail, while at the same time evading the questions of principle, has been on this occasion denied to us. Nor is much further light to be gained by turning to the attitude of the two Funds with regard to other London skin hospitals. The Blackfriars Hospital for Skin Diseases in Stamford Street, for instance, is known all over the world as one of the famous, and, indeed, classical centres of medical specialism. Its career has been no less honourable than its work has been scientific. Yet this hospital is consistently boycotted by the Sunday and the King Edward's Funds. If this be done on the ground that the premises are unsuitable for hospital purposes, it may, on the other hand, be reasonably urged that the bulk of the work is among out-patients, and that the wards answer well enough to the test of the ratio of in-patient mortality—a sufficiently searching practical test. In a word, the exclusion of the Western and the Blackfriars Skin Hospitals from the grants of the Hospital Sunday and King Edward's Funds, in our opinion, demands instant explanation if the public is to trust the wisdom and impartiality of those funds. Let us now turn to St. John's Hospital, to which repeated grants have been made by the Sunday and one recently by the King's Fund. Without wishing to rake up past occurrences, it is notorious that within comparatively recent years grave public charges have been made against the management of the hospital—charges that have not been disposed of satisfactorily either in the law courts or elsewhere. Nor has the subsequent history of the institution been of a kind calculated to re-inspire confidence. The definition of the word “hospital” has no doubt engaged the attention of the Funds from time to time. Have they ever seriously inquired, we wonder, what is the claim of St. John's Hospital to that name? On January 15th, 1890, St. John's was registered as a Friendly Society. For some reason or other the management became dissatisfied with that arrangement, and in 1900 they wound up the Society and enrolled themselves as a limited liability company. Why it should be desirable for any self-respecting and honourable medical charity to take either step must be to most men an unfathomable mystery. At present the Board of Management is self-appointed and autocratic. The so-called governors have practically no power in the affairs of the hospital. One member of the honorary medical staff, we notice, is a director of this strange company. We venture to ask if the Hospital Sunday and the King Edward's Funds were fully acquainted with this state of affairs when they devoted the money of the charitable

public to a hospital that feels constrained to adopt the machinery of commercial undertakings in order to administer to the wants of the sick poor? Yet the Sunday and the King Edward's Funds can find money for this company in spite of its past history and its present curious constitution and its unauthorised management, while other skin hospitals, like Blackfriars and the Western, with untarnished histories, are sent empty away. It seems certain that unanswered charges against the management of a hospital in the columns of *Truth*, however often repeated, do not disqualify that charity from the awards of the Funds. Otherwise the Queen's Jubilee Hospital would have fared badly, instead of receiving a fair share of grants. It is to be hoped that the points raised in connection with the small hospitals will be seriously considered by the Councils of the Hospital Sunday and the King Edward's Funds. Our criticism is offered in full recognition of the splendid work achieved by those bodies. It is conceived, we trust, in a spirit of fairness and of public-spirited love of justice such as are known to appeal to the unflinching practical wisdom of the King and of the Prince of Wales. In offering these criticisms we are glad to think that the Funds have not tied our hands in any way by including the Editor of THE MEDICAL PRESS AND CIRCULAR in the list of Councillors, where medical and nursing journalism is already amply represented by the *Lancet*, the *British Medical Journal*, and the *Hospital*. Should the Funds appoint committees of inquiry into the Orthopædic Hospital Amalgamation, the St. John's Hospital Constitution, and other matters raised by us in the present series of articles, we can as an independent journal place a number of interesting documents at their disposal.

POISONING BY WOOD SPIRIT.

A LITTLE over twelve months ago we drew attention to a series of cases of grave or fatal poisoning in America resulting from the use of methyl alcohol. Since that time the number of cases has increased so largely that it is worth while again to point out the great danger to the public from the careless use of this spirit. In these countries one but rarely hears of anyone drinking methylated spirit, for the taste and odour are so unpleasant as to be deterrent, while grain alcohol is, unfortunately, so easily got as to be within the reach of all who seek alcoholic stimulation. In the States, however, where in many districts the sale of grain alcohol is either altogether prohibited or fenced round with many difficulties, people are prone to look for some substitute. In addition, during the last few years it has become customary to deodorise methyl alcohol in order to make use of it in various culinary and toilet preparations, such as essence of lemon, bay rum, "colonial spirits," witch hazel extract, and others. When made up in these elegant forms there is little doubt that methyl spirit may be used for the adulteration of whisky and other forms of ethyl alcohol. In the immense majority of the cases of poisoning

the persons affected have been of alcoholic habits and have taken to the drinking of the methyl spirit, either from a liking for it or as a substitute for unattainable ethyl alcohol. The fatal dose is usually from four to eight ounces, though serious effects have followed a dose as small as half an ounce. This being so, we need not wonder that poisoning sometimes occurs by inhalation of the vapour, and sometimes by absorption through the skin. For instance, persons who had used alcoholic washes or liniments were found suffering from optic neuritis, and a similar lesion has been found in tradesmen who had to use methyl solutions in the arts. In manufactories where large quantities of methyl spirit are used it has, therefore, been found necessary to arrange an extra supply of fresh air to the workers. The most constant symptoms of methyl poisoning are mild intoxication followed by severe headache, gastric pain, retching, dilatation of the pupils, and partial or complete blindness. In the most serious cases this sequence is followed by dyspnoea, coma with stertorous breathing, and death. The toxic amblyopia is of all these symptoms the most constant and important, since even when recovery takes place, atrophy of the optic nerve is likely to follow the neuritis, and a permanent blindness is the result. The immediate cause of death in fatal cases is not quite clear, though respiratory paralysis sometimes precedes circulatory failure. It is thought that the toxicity of the drug may be greatly increased by the production of formates in the body by the decomposition of the methyl alcohol; and formates have been discovered in the urine. Whatever be the exact pathology of the condition, there is no doubt that the intense toxicity of methyl alcohol calls for extreme caution in its use. It is, moreover, the duty of the profession to see that the public are properly instructed on the point.

UNDERFERD CHILDREN.

THERE is a wonderful tendency in the human mind to worship its own creations. In the savage and lowly-civilised this tendency shows itself in stark idolatry; in their more developed descendants it assumes the form of reverence for laws and official systems. Whilst a proper regard for the organisation of the State is a commendable trait in a nation, it is always apt, unless incessantly controlled and checked, to lead to undue worship of the form and undue regard for the aim for which the organisation exists. Familiarity with the institution tends eventually to obliterate the notion that the whole aim of the army is to fight, the law to administer justice, and the school to educate. If, however, the ultimate objective of a system be always kept clearly in view, it should be obvious to the meanest intelligence that unless the conditions necessary for efficiency are provided, the system itself becomes a mere fetish. Now, in all the embittered controversies on the religious question in elementary schools, and the only less heated ones on the curriculum to be

followed in them, the fact that it is absolute waste of time to teach children religion, arithmetic, or physical exercises unless they are in a fit state to learn has been most strangely overlooked by the partisans. Receptivity in the pupil is a necessary antecedent to instruction of any kind, and educationalists would do well to appreciate that elementary, cardinal, and obvious fact. The child who is mentally deficient, physically ill, or actively hungry is not in a state of receptivity, and the sooner he is eliminated from the school class, the better will it be for the teacher, the class, and himself. Mental deficiency and actual illness are more or less already provided for or guarded against, but the hungry child is officially non-existent. He is of school age and he can walk; therefore he is hunted to school by diligent attendance officers, and there left for his teacher to make the best job of him he can. The sheer stupidity of this routine performance is fortunately beginning to strike those educationalists who prefer furthering the mental and physical welfare of the child to winning ephemeral triumphs at by-elections. An army, one knows, moves on its stomach; a child is educated on the same viscus. Given average or even good mental and physical powers, there can still be no instruction conveyed to a child till his stomach is lined. If reasonable nutrition were made a necessary antecedent to school-teaching, there would, at least, be a prospect of some good accruing to the unfortunate object of educational experiments. The extent to which under-feeding, as it is euphemistically termed, exists is difficult to ascertain, but all medico-educationalists are agreed that in the elementary school children in large towns the proportion is sadly high. Dr. Eichholz, in his evidence before the Physical Deterioration Committee, put the number in London at 122,000, a proportion of no less than 16 per cent. of all London pupils. Dr. Kerr, of the London School Board, puts the number at only 10,000, but he estimates that 10 per cent. of the children are incapable of receiving benefit from school-teaching from starvation and similar causes. But whether the total be 122,000 or 10,000, it may unhesitatingly be said that the public money expended on teaching them is utterly and irretrievably lost. Dr. Eichholz, by taking the children in three schools in typically poor neighbourhoods, has shown that proportions of 74 per cent. in Notting Hill, 72 per cent. in Lambeth, and 69 per cent. in Finsbury, never rise above the three lowest school standards, whilst in the bottom class of all it is no uncommon phenomenon to find half-starved children of eleven, twelve, and even thirteen years of age. General insanitary conditions play a rôle, doubtless, in producing this mental obtuseness, but it cannot be allowed to be a large one. The prime and essential factor is the want of adequate nourishment. The difference that can be wrought in the general intelligence by providing sufficient, though not a redundant, quantity of food has been shown by the enlightened experiments of Dr. Hall, of Leeds.

Out of his own pocket this philanthropic gentleman started a scheme for providing cheap meals for a number of the poorest children, and in the short space of a fortnight was able to obtain an amount of physical growth and general improvement that was astonishing. By going carefully into the matter he found it possible for the ridiculously small sum of a penny to provide a wholesome meal for a child if fed in the school building and waited on by willing elders, and by two such meals a day to a hundred children he obtained in the first ten weeks an increase in weight per child of from one to five pounds. Certain voluntary agencies are doing something already in London to serve the poorest children through the coldest months of the year with one good meal a day, but far more than this is needed. The question of parents evading their natural responsibilities has, of course, to be faced, but until the children are fit to be taught it would seem elementary economy to suggest giving them bread before, or if necessary in place of, instruction. The question is ripe for the pen of a Dickens to do for the elementary school child what he did for the middle-class boy by his sketches of life at Dotheboys Hall and Salem House.

Notes on Current Topics.

The Edalji Case.

OUR readers will remember the steps taken by THE MEDICAL PRESS AND CIRCULAR in November, 1903, to bring about a revision of the trial of Mr. Edalji, the young Birmingham solicitor who was sentenced to seven years' penal servitude in the October of that year for maiming a pony at Great Wyrley. We felt at that time that the evidence on which the conviction was obtained was far from conclusive, and, moreover, that if Mr. Edalji were actually guilty of the crime with which he was charged, the act indicated a degree of mental disease that should have sent him to the asylum rather than to prison. A petition was started by this journal; and the signatures of a large number of medical men engaged in every branch of practice having been obtained, the document was forwarded to the Home Secretary. Beyond the usual official acknowledgment, nothing further has been heard. Since then we have commented from time to time on the matter, but without appreciable result. Now we are glad to see that our able and vigorous contemporary, *Truth*, has taken the matter up on its own account, and, after going carefully into the evidence and weighing each item with judicial impartiality, sums up its articles strongly in favour of the condemned man. As the Beck case is being cited *ad nauseam* by advocates appearing for every prisoner in the country, we are unwilling to do more than refer to it in this connection. The investigation in that case showed that the Home Office is not only fallible like all other human agencies, but at times even stupid. We feel we have no guarantee that our petition even reached

the heads of the department, and none that the evidence in the trial has been reviewed by anyone with legal training. We, therefore, join with *Truth* in demanding that the whole case shall be reviewed afresh by trained and impartial minds. It is difficult to escape the conclusion that either Mr. Edalji is an innocent man, as the continuance of the outrages after his imprisonment suggests, or he is a poor madman who should be cared for in an asylum.

Fresh Air and Phthisis.

DURING the past five-and-twenty years there have taken place in ordinary practice many changes in the treatment of consumptive patients. We all remember when it was considered the perfection of treatment to guard the patient against every chance draught, and when a chill was regarded as the most dangerous of occurrences. Even at that time, however, there were a few here and there who cried out that fresh air was not only harmless but beneficial to consumptive patients, and practised their doctrine with success. A few years ago all this had changed and opinion had shifted so much to the opposite extreme that fresh air had actually come to be regarded as a specific cure for phthisis. The era of sanatoria had begun, and a general idea prevailed that not only was phthisis curable, but that every case was so. What is our position at present? It is impossible to give any definite judgment as to the value of sanatorium treatment, for the time of trial is still too short, and the figures are difficult of collation. Nevertheless, it is safe to say that, although sanatorium treatment has fallen far short of the wild hopes held five or six years ago, it is certainly the best method of treating phthisis. We believe, too, that while the cult of fresh air is becoming saner in its evolutionary tactics, it is being recognised that its usefulness is capable of wider application; for not only in phthisis, but in all other diseases of the lungs—pneumonia, whooping-cough, broncho-pneumonia—has fresh air been found to have a beneficial effect. The belief in fresh air as a specific for tubercle is waning, but its importance in therapeutic hygiene is becoming more recognised every day.

Women and Quack Doctors.

WE commented some months ago on the excellent work which an American paper for ladies, *The Ladies' Home Journal*, has been doing by its crusade against the use of secret medicines. We are glad to see that in a recent number the writer of the previous articles, Mr. Edward Bok, is continuing his task by an exposure of the methods of the advertising doctor who gives his "personal advice" to all and sundry who care to apply. It is hard to believe that any woman who reads the article will ever allow herself in future to be gulled by one of these ravenous impostors. Mr. Bok gives, from inside knowledge, a detailed statement of the manner in which one of these medicine-businesses, which makes a special profession of "personal attention" and "confidential commu-

nications," is conducted. The advertisements issued contain references to "the private diseases of women," "special troubles of the sex," and so on, and an assurance of absolute privacy with regard to correspondence is given. "The Great Doctor," however, whose "personal advice" was to be given, spends nearly all his time yachting or in the country, and is in reality a man who had failed to become a regular physician. Letters asking for advice are opened by a score or so of "mail-openers," and a foreman having marked a number on each letter, the reply corresponding to that number is despatched. The "chemist" of the establishment had entered it a few months before as hall porter, but has been promoted. The medicine supplied is nearly half alcohol, so that most of the unfortunate patients become fond of its use. *The Ladies' Home Journal*, both by the publication of such articles and by the conduct of its advertising columns, offers an example which might be well followed by our society journals at home.

Cremation.

It is now almost twenty years since the first crematorium in Great Britain was opened at Woking. At that time the movement to substitute cremation for earth-burial as a means of disposal of the dead met with the bitterest opposition. Public opinion looked on the proposal as little less than sacrilegious, and clerics denounced it in round terms from their pulpits. At the present day all this opposition has died out, and the advocates of cremation have to complain rather of apathy on the part of the public than of any active hostility. There is no doubt, however, that the idea is gaining ground among the better educated members of the community; and the number of cremations annually performed increases year by year. There are at present nine crematoria in the Kingdom, of which eight are in England and one in Scotland, while, naturally enough, considering the conservatism of the inhabitants of that island, there is none in Ireland. This year two new institutions will be added to the number—one at Ilford, and one at Bradford. The number of cremations performed each year is now nearer six than five hundred, and is likely to increase in the future. Indeed, one of the principal obstacles at present to the more general adoption of cremation is the expense attached, and this can only be materially reduced as the process gains in popularity.

An Operation for Pruritus Ani.

AT first thought one is inclined to regard a radical operation for the relief of pruritus ani as somewhat heroic treatment, but no one who has seen a really grave case is likely to concur in this opinion. There is perhaps no suffering more trying to the spirits of a patient than the constant and unremitting annoyance caused by the itching of this disease, while the mental misery is only increased by the fact that the physical health of the

patient is usually unaltered in other particulars. In its general effect on the patient's mental condition it resembles trifacial neuralgia, and it is now fully recognised that this disease demands and justifies, in cases of extreme severity, the most far-reaching operative measures. Various suggestions have been made as to the best surgical means to be adopted for relief of pruritus ani, and Sir Mitchell Banks was in the habit of destroying the superficial layers of the skin by the cautery. Other surgeons have practised the complete excision of the affected skin, as has also been done in the similar condition of pruritus vulvæ. A neater and, we think, more scientific method of treatment is that recommended by Sir Charles Ball in a recent paper. He suggests the section of the sensory nerves of the part, and he performs the operation by carefully separating the skin around the anus from the underlying tissues, and thereby rendering it anæsthetic. The operation has been practised with complete success in several cases, the relief having lasted up to the time of writing, a period in some cases of a couple of years. Sir Charles Ball suggests that where this operation fails, it should be considered whether it is not advisable to excise the ganglia of the posterior roots of the third and fourth sacral nerves.

Gonorrhœal Rheumatism in Infancy.

A RARE condition was reported to the Rouen Medical Society by M. Magniaux at a meeting this month. (a) A woman suffering from a leucorrhœal discharge was confined, and her infant soon afterwards developed purulent ophthalmia in both eyes. This condition in the infant was succeeded by synovitis of the extensor tendon-sheaths of the left hand, of the extensor and flexor tendon-sheaths of the left foot, of the left tibio-tarsal joint, of the left shoulder-joint, and some periostitis of the sternum. Unfortunately no bacteriological examination was made of the vaginal discharge of the mother or the pus from the child's eyes, but taking the clinical history and manifestations together, M. Magniaux points out that there can be no reasonable doubt but the child was the subject of the disease generally known as gonorrhœal rheumatism. Acute rheumatism is notoriously uncommon in the newly-born, but gonorrhœal rheumatism is less rare. M. Magniaux has collected fifteen cases from literature in which the conjunctival infection alone was the starting point of a generalised infection by the gonococcus, and he considers it impossible to draw any other conclusions from the case under notice. Happily the prognosis of gonorrhœal rheumatism is much brighter in infants than in adults, and in the instance mentioned by M. Magniaux the lesions all subsided completely.

Medicine in the Novel.

WE are accustomed in reading fiction to come across clinical descriptions of diseases which puzzle the sharpest diagnostic acumen, and we have long

ago given up attempting to solve such enigmas. We have ceased, too, to wonder at the frequency with which heroes and heroines suffer from "brain fever," a title unknown to the Royal College of Physicians. But, when a medical man writes a novel, we might expect him at least to exercise some little care, and, for the sake of his discarded professional reputation, to write accurately on matters of medical bearing. It is, therefore, more in sorrow than in anger that we find fault with our quondam brother, Sir Conan Doyle, for some of his recent writings. In "The Adventure of the Golden Pince-Nez," Sherlock Holmes makes the statement, shocking to every oculist, and, indeed, to all of us, that a short-sighted lady wears convex glasses "of unusual strength," and is "really helpless without them." It is disappointing that a man of the great detective's perspicacity should be permitted to fall into a blunder which will obviously put him on the wrong track, but it is disconcerting to our professional pride that his friend, Dr. Watson, is unable to set him right. Again, in "The Adventure of the Second Stain," we learn that a blood-stain, several days' old, was a brilliant "crimson." This should have raised some doubts in the mind of a man of such experience of blood-stains as Mr. Holmes, not to speak of Dr. Watson, and surely Sir Conan Doyle must have seen some blood-stains during his South African experiences, even if he has quite forgotten his student days. However, Kingsley, who liked to be regarded as a naturalist, once addressed the lobster as "cardinal of the seas"!

Undesirable Immigrants.

THE glass of fashion in the treatment of consumption is a kaleidoscopic one. Sir Samuel Wilks, in an entertaining article the other day, recounted the number of crazes in dealing with pulmonary tuberculosis that he has seen in vogue in the course of his long life. The earliest that he could remember was the treatment of pumping hydrogen sulphide up the rectum, and the latest the fresh-air mode. The former used to be wittily described by a popular lecturer at one of the London hospitals as appearing to him to be fashioned on the principle of sending coals to Newcastle, whilst the latter is still with us. One phase that it may be hoped will soon be buried in oblivion is that of posting off bad cases to the Southern hemisphere "to give them a last chance." The last chance might often be described as a *coup de grâce*, for medical men at the Cape and in the Antipodes are continually complaining of the number of hopeless cases that are landed on their shores to die. This form of dumping is resented by our Colonies as much as the dumping of tin-plates or steel rails is by our tariff-reformers; and now that sanatoria are "dotted about through the length and breadth of the land," it may be anticipated that the consumptive will be retained for the home market in greater numbers than before. Even the worm will turn, and Mr. Seddon is as little like a worm when he is roused as can

(a) *La Méd. Moderne*, January 8th, 1906, p. 22

be imagined. A deputation waited on him at the beginning of the year to ask for a Government grant towards a home for consumptives; it seemed to have departed with something like a flea in its ear. Mr. Seddon said that every steamer that came to New Zealand brought consumptives, many in advanced stages, and that the Colony was being used as a dumping ground by Great Britain. He threatened to take strong measures if the process of immigration was continued, and Mr. Seddon is known to be as much a man of action as of words. It is well for medical men to bear in mind the great responsibility they incur in sending patients in any but the very earliest moments of the disease to distant countries, especially to such as are not able to provide them with all the amenities of life to which they have been accustomed at home.

Attendance in Confinement.

WITH every wish to recognise and act up to the spirit of charity that pervades our voluntary hospital system, it cannot be a matter for wonder that attendance on the unspeakably filthy foreigners that throng the doors of some of our East End charities is a considerable trial to the medical men and nurses concerned. The discomfort of the situation is not lessened by the manners and customs of many of these aliens, who treat the charity dispensed to them as though it were their birthright, and many stories come to our ears of the annoyances that are met with at their hands. One of the students working in the extern midwifery department of the London Hospital was recently subjected to an outrage of a particularly offensive character the other day. He was called at night to a confinement in some buildings in Whitechapel, and finding that some hours would elapse before his services were needed, told the husband that he was going back to the hospital and would return later. This individual, by way of showing his appreciation of the gratuitous services rendered to his wife in time of trouble, promptly locked the student in the room and kept him there for three and a half hours till the baby was born, while for all he cared another woman might have been requiring the student's attendance. The alien question is a sufficiently serious one in itself, and the difficulties of solving it by a statesmanlike means will not be lessened by actions of this kind. If the East End foreigners excite prejudice against themselves they are likely to find that the legislation that is pending with regard to them will not be so lenient as many desire it should be.

Syphilis in Animals.

THE researches of Metchnikoff and Roux into the etiology of syphilis are being energetically pursued, and some of their more recent results, both positive and negative, are of great importance. It has now been established by these inquirers that the syphilitic *contagium vivum*, whatever be its exact nature, is not of very minute size, for it

is incapable of passing through a Berkefeld filter. Most of the pathogenic bacteria are similarly stopped by this filter, but there are certain micro-organisms, and these not of ultra-microscopic size, which can pass it. Metchnikoff and Roux show, also, that the syphilitic virus is destroyed by heat, an exposure to a temperature of 50° C. for one hour rendering it incapable of producing infection. Glycerine, however, has, as far as has been observed, no effect on its pathogenicity. The organism is probably non-motile, for no movement could be made out in a fluid containing it in suspension. Several attempts have been made to produce a vaccine either by artificial attenuation or by simple diminution of dose, but so far results have been entirely negative. The difficulty seems to be that, while some species of monkeys, notably the chimpanzee, possess a susceptibility to syphilis similar to that in man, in other species susceptibility is entirely absent. Metchnikoff is anxious to find some species which is inoculable by syphilis but at the same time possesses sufficient resistance to develop only local lesions and not suffer general infection.

Sir Frederick Treves' Book.

IT is given to but few members of the profession to be able to retire at a comparatively early age with eye undimmed and natural force unabated. And to those who can there are even less seldom added a European reputation and an ample competency earned by unquestionable professional pre-eminence. Such, however, is the enviable position of Sir Frederick Treves, and true to the instincts that have built up his success he finds his diversion in a change of work. It was generally known that his recent tour round the world was to be productive of a book on his experiences, and now that book has been published there are few, we think, who will not take pleasure in reading the comments of so acute an observer on the phenomena that he encountered. With all eyes turned to the East, it is to Sir Frederick Treves' impressions of Japan that people will look with the keenest interest, and it is noticeable that he thoroughly endorses what Miss McCaul has recently said about the efficiency of the Japanese Red Cross Society and military medical arrangements. Coming on top of Sir Frederick's experiences in South Africa, it is particularly significant that he is able to say of the Society that it is the most remarkable and efficient of its kind in the world, and that whereas in the late war this country lost by death 13,250 soldiers from disease, most of which was preventable, the Japanese under conditions of greater rigour, and in operations on a far larger scale, have lost but a fraction of 1 per cent. from similar causes. The Japanese nurses would seem to be not the least marvellous product of a rejuvenated civilisation. The dexterity of her small hands in using a pair of forceps "only a prestidigitator could mimic, and only a life-long use of chop-sticks could explain." But even Japan is not free from quacks, and from Sir

Frederick's account they yield nothing in blattancy and chicanery to our own worthies.

Bread Substitutes in Diabetes.

THE chief difficulty in the treatment of diabetes mellitus lies in adjusting the diet to the particular case in hand. It is bad enough for the patient to be deprived of certain dishes which, from long use, he has learned to look upon as almost a daily necessity. The trouble is far more real in the case of the poor, to whom ordinary white bread and potatoes are indispensable, and for which there is practically no cheap substitute. It is a well-known clinical fact that the worry induced by the enforced abstinence from some customary article of food does as much harm to the diabetic as its ingestion in moderate quantity. At any rate, there is an increase in the quantity of sugar passed when a patient begins to pine and fret after a slice of bread-and-butter, which he has been told by his physician on no account to take. The gratification of an earnest longing of this sort, within limits, will probably do him more good than the most expensive, but unpalatable substitute. Many of the so-called "diabetic," breads and foods undoubtedly contain quite an appreciable quantity of carbohydrates, whereby their virtue is, of course, correspondingly impaired. There are very few that are really liked by patients, and the price of the majority militates greatly against their general consumption. Dr. R. T. Williamson, (a) of Manchester, classifies the bread substitutes into (1) the vegetable albumens, such as gluten, roborat, and aleuronat; (2) nuts, including the almond and the cocoanut; and (3) the milk-albumens, such as plasmon, protene, and casoid. These latter contain 82 per cent. of proteids, and they are practically free from carbohydrates. The nut-tribe are apt to give rise to dyspepsia, owing to their contained fat. The best plan appears to be to get the patient to try one after another until he hits upon one which suits both the palate and the pocket. Home-made preparations made from one of the starch-free flours are often more satisfactory than the bread as usually sold.

PERSONAL.

It is officially announced that the following additions to the list of the Honorary Medical Staff for King Edward VII.'s Hospital for Officers, appointed by the Prince of Wales, President, have been approved by the King, as Patron:—Mr. Watson Cheyne, M.B., C.M.Edin., F.R.C.S., F.R.S.; Mr. Pearce Gould, M.S., F.R.C.S., Honorary Surgeons; and Dr. Bruce Porter, Honorary Physician.

TOWARDS the cost of the whooping-cough wards, &c., now in course of erection, the trustees of the estate of the late Mr. Siegfried Rudolf Zunz have offered to make a grant of £3,000 to the East London Hospital for Children at Shadwell, on condition that a ward be named the "Annie Zunz" ward, and that the balance of the money required to complete the building be obtained by June 30th next; £10,000 in all is still required.

We understand that £157 10s. was realised by the

(a) *Practitioner*, January, 1905.

annual ball of the Royal Isle of Wight Infirmary and County Hospital, which was attended by Princess Henry of Battenberg, President of the hospital.

MR. W. THORBURN has been elected President of the Manchester Medical Society for 1905.

MR. WALTER WHITEHEAD has been elected a member of the Court of Governors of the University of Manchester. The Manchester Edinburgh University Club has elected Professor A. H. Young, of Manchester, President for the year. It is expected that Sir William Turner, K.C.B., Principal of the University of Edinburgh, will be the guest of the club at the next annual dinner.

ON January 27th Sir W. H. Preece opened the new electro-therapeutic department recently added to the Cardiff Infirmary.

SIR PETER EADE, Consulting Physician to the Norfolk and Norwich Hospital, celebrated his 80th birthday on January 19th, and was presented by his colleagues on the staff of the hospital with an address, accompanied by a presentation in recognition of the high esteem in which he is held by them.

A BANQUET in support of the London School of Tropical Medicine will be held in London on May 10th. Mr. Chamberlain will preside. The Duke of Marlborough has consented to be Chairman of the Dinner Committee.

THE President of the French Republic has conferred on Dr. George Ogilvie, Senior Physician to the French Hospital, the much-coveted decoration of Chevalier de la Légion d'Honneur. Dr. Ogilvie has been on the staff of the French Hospital for some eight or nine years.

SIGNOR MANUEL GARCIA, who completes his 100th year on March 17th, will be presented by the Spanish Ambassador with his portrait, by Mr. John Sergeant, R.A., at a reception at the Hotel Cecil, and a dinner will be held the same evening at which ladies will be present.

DR. ROBERT J. ROWLETTE has been appointed Pathologist to the Rotunda Hospital, in place of Dr. W. C. Neville, deceased.

It is officially announced that Dr. L. D. Parsons, Resident Surgeon-Superintendent of the New Providence Asylum, Bahamas, is to succeed Dr. J. E. Ker as Assistant Surgeon, Colonial Hospital, Police and Port Surgeon of Gibraltar. Dr. E. Ker has proceeded to Jamaica as Superintendent Medical Officer.

MR. WILFRID ALLPORT, M.B., B.S.Lond., F.R.C.S. Edin., was last week appointed to the vacancy of Ophthalmic Surgeon at Queen's Hospital, Birmingham, to fill the vacancy caused by the resignation of Mr. Priestley Smith. Mr. Allport was a Birmingham medical student, and was formerly resident obstetric and ophthalmic surgeon at the Queen's. He was for two years at the Midland Eye Hospital in Birmingham, and for five years has acted as assistant ophthalmic surgeon to Mr. Priestley Smith.

ON the occasion of his retirement from the Glasgow Parish Council, after 20 years' service, a large gathering of friends of Dr. Wilson Bruce presented him last week with an illuminated address. Mr. Henry E. Clark, C.M.G., President of the Faculty of Physicians and Surgeons, presided over the meeting.

WE deeply regret to announce the death of Professor Ambrose Birmingham, Professor of Anatomy in the Catholic University School of Medicine. We publish elsewhere a memorial address delivered at the School by Sir Christopher Nixon, M.D.

DR. HENRY O'NEILL, a prominent member of the Belfast Municipal Council, has been nominated as High Sheriff of the city for the ensuing year. We understand that he is the first medical man to hold this post in Belfast.

Mr. E. WHITLEY, B.A., Trinity College, Oxford, has given £1,000 towards the permanent endowment of the Chair of Pathology at the University of Oxford.

SIR WILLIAM CHURCH has written to the Vice-Chancellor of Oxford, informing him that at a meeting of medical graduates in London, resolutions were unanimously passed declaring it desirable in the interests of medical education at Oxford that steps be taken to bring before the university the necessity of permanent and adequate support being received for the pathological department, and that a fund be started for the purpose of assisting.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

SCOTLAND.

GLASGOW NORTH-WESTERN DIVISION OF THE BRITISH MEDICAL ASSOCIATION.—A general meeting of the above Division was held in the Burgh Hall, Byars Road, on Tuesday evening, the 24th ult. The Chairman of the Division, Mr. Thomas Richmond, presided, and explained that the Executive Committee had considered the best means to adopt by way of having a good attendance of members at the meetings. It had been arranged to issue complimentary invitations to the medical men in the Division who were not members of the B.M. Association, with the result that the attendance at Thursday's meeting was encouraging; in fact, it was what the Chairman ventured to call a record attendance over the various Divisions in the city. He went on to explain further the advantages and opportunities now given to members of the Division of having professional grievances redressed, emphasising the urgent need for hospital reform in several directions in the interest of the general practitioner, who suffered so seriously from a large class of patients being admitted into general and special hospitals who were quite able to pay doctors' fees. This was particularly noticeable, he said, in cases where an operation was requiring to be performed. He expressed his regret at the apparent indifference shown by many members with regard to matters of great importance which were brought before the Divisional meetings. The business of the evening was the discussion of the seven propositions on Contract Medical Practice contained in the Supplement to the *British Medical Journal* of November 26th, 1904. They were fully discussed by the members, and thereafter agreed to, it being generally considered that they very fairly represented all that was required.

GLASGOW SOUTHERN MEDICAL SOCIETY.—This Society held its annual supper in Ferguson and Forresters', Buchanan Street, on the evening of Thursday, the 26th ult. The President (Dr. James Hamilton) occupied the chair. The company numbered between fifty and sixty. After the loyal toasts had been proposed from the chair and duly honoured by the company, a programme of music was entered upon. Song and recitation followed in quick succession, among those contributing being Drs. J. R. Monro, Wauchope, McMillan, Smith, Patrick, and Messrs. Weir, Smith, Hope and Wilson. The evening's enjoyment was brought to a close by the late President in a few appropriate remarks proposing the health of the Chairman, Dr. Hamilton, to which he replied in a few well-chosen sentences.

APPOINTMENT FOR DR. JOHN KNIGHT, GLASGOW.—The above-named gentleman has just been appointed Medical Officer of Health for Scarborough, vacant by the resignation of Dr. Dittmar, who was recently appointed Medical Inspector for the Local Government Board of Scotland. Dr. Knight is at present assistant

to Dr. Chalmers, Medical Officer of Health for Glasgow. There were forty-three applicants for the office now secured by Dr. Knight.

BELFAST.

THE ROYAL VICTORIA HOSPITAL.—The Board of the Royal Victoria Hospital is being sharply criticised in the Belfast press for a proposal which seems to have found favour with a number of its members, and which is to come up for discussion to-day. The proposal is one to increase the salary of the Superintendent of the hospital. The gentleman who holds this post is a retired colonel of the Indian Medical Service, from which he presumably has a good pension. His salary at the Royal Victoria Hospital is £300 per annum, and he is being provided with a spacious new house in the grounds of the hospital, with free fire and light. As urgent appeals are constantly being made for funds to enable the Board to open the wards which are at present lying idle and empty for want of money, it certainly seems rather a tactless thing for this gentleman's friends to ask for an increase of salary at the present time.

THE WORKHOUSE CONSUMPTIVE SANATORIUM.—Forty patients have already been taken into the Consumptive Sanatorium at the Abbey, Whitehouse, from the consumptive wards of the Union Infirmary. As the number of phthisical patients generally runs to about 240 or so, a good deal more accommodation is needed, even to take in only the less advanced cases. This will be provided by huts built in the grounds, the present accommodation being in the house itself. An amusing instance of medical optimism occurred at a discussion on the structure of these huts, at last week's meeting of the Belfast Guardians. The point at issue was whether the huts should be built of stone or wood, and one of the members of the Board solemnly gave as a reason for the temporary form of hut the fact that one of the doctors had informed him that there would be no consumption in fifteen years' time!

THE CORONERSHIP OF THE CITY.—The death of Mr. Finnegan has created a vacancy in the office of Coroner for the City of Belfast, and naturally the appointment of his successor has much interest for medical men. The late coroner was a solicitor, who had been a prominent politician before his appointment, but it is expected that his successor will be a medical man. The favourite candidate for the post is an ex-alderman, a medical man who lately retired from the Municipal Council, and who is known to be a general favourite with the members of that body. No doubt the post will be conferred as a reward "for services rendered," and the best we can hope is that the recipient may happen by chance to be a suitable man, for suitability or otherwise will not count for much with the Municipal Council.

NEWTOWNARDS DISTRICT NURSING SOCIETY.—At the annual meeting of this society, held last week, the chair was taken by the Marchioness of Londonderry, who has before now shown a deep interest in the Society. In emphasising the great advantage derived by the poor from the nurses' visits, she remarked that the nurse was a technical educator in the matter of soap, diet, disinfection, and fresh air. She also laid stress on the point that the nurse could see that proper attention was paid to the doctor's orders.

THE LATE PROFESSOR BIRMINGHAM.

ADDRESS BY THE DEAN OF THE MEDICAL FACULTY OF THE CATHOLIC UNIVERSITY SCHOOL OF MEDICINE.

SIR CHRISTOPHER NIXON, after some introductory remarks, said:—If I might, in a brief way, analyse Birmingham's splendid abilities, I would do so under three heads—as a teacher, as an original observer, and in reference to those qualities which made his personality so attractive to all who knew him. As a teacher he was the nearest approach to the ideal that I have had experience of. With the most thorough

knowledge and grasp of his subject, he possessed the rare gift of making it transparently clear, and by a bright and vivid description invested it with such interest as to excite the rapt and sustained attention of his class. No pains were spared in presenting his subject with all the adjuncts which the most modern methods of demonstration require, and each lecture was, in the most practical way, illustrated by diagrams, models, and lantern accessories, so that an indelible impression was left on the mind of the anatomical part that was dealt with. The subject matter was presented in a way so striking and complete, so replete with illustration and so precise in form, that even to the first year's student the description of a bone was as interesting as the practical points in surface anatomy were to the most advanced student. Altogether, apart from his brilliant work as a teacher, work which, taking into consideration its constancy and laborious nature, must have kept his hands full, he found time to carry on researches with such brilliancy as to make us realise what he might have done if he had only been decreed the allotted span of human life. His three papers on the mastoid region, published in 1893, so important in their surgical aspect as to form the basis of operative procedure in this region, made the name of the young anatomist so well known that a leading aural specialist came to Dublin to examine his preparations. His work on the position of the stomach, the anatomy of the peritoneum, and of the abdominal viscera generally, is, in some respects, of an epoch-making character, whilst it exhibits a capacity for investigation which raised the author to a high level as an accurate, painstaking, and original observer. When Professor Cuninghame brought out his great work on anatomy, a work representing the collaboration of the leading anatomists of the Empire, with a generous appreciation of a rival professor's merits, he entrusted the portion of the work dealing with the anatomy of the abdomen to Birmingham, with the result that the consensus of expert opinion gave the palm of merit to Cuninghame and Birmingham for their articles. Surely this is a record which amply justifies his Eminence Cardinal Logue's generous appreciation, when he writes of Professor Birmingham—"His loss is a national loss, and at a time, too, when Catholic Ireland stands in such need of her staunchest Catholic children." The last aspect under which I may refer to Birmingham was his wonderful capacity for organisation, and his striking personality. From the time he took up the Registrarship of the School, in 1887, the institution entered upon the course of progress in every aspect and in every detail. Its finances were dealt with with the ability of a chartered accountant; each professor realised how essential it was to support in every way the man who was devoting his life largely to the vindication of a principle, and in antagonism to a bitter and relentless denial of educational rights and privileges; whilst the students felt that they were under the influence of one who exacted their respect and gained their affections. Not that Birmingham employed the customary aids, adventitious or otherwise, to gain popularity or notoriety. He was a perfectly straight man, with the highest ideals of what was due from man to man, and it was this that largely explained the singular influence which he exercised upon students. *Obsequium amicos, veritas odium parit*, however true it may be generally, could not be said to apply to him. He was the true friend of the students, never more so than when he reproved their faults, set his face against idleness or bad habits, and enforced that degree of discipline and decorum which I am glad to acknowledge is the characteristic of the modern type of students of medicine. But, if he were a disciplinarian, how just and gentle was his rule, how impartial and tolerant his methods, how earnest and thorough was his desire for your welfare, how unassuming and unvarying his relations with you all. You might say of him—

"Rich in saving common sense
And, as the greatest only are,
In his simplicity sublime."

For myself, I may say that to me the death of Birmingham has been a severe wrench. More than a moiety of a lifetime devoted to the interests of this school, I confess the loss to one of whom I was bound by all the ties which unite a favourite pupil, colleague, and friend, is a most trying one. But there is a solace which helps to dispel the gloom that affects us all. Mainly through Birmingham's work, and through the co-operation of all whom I see around me to-day, the future will not be imperilled by the loss of any individual, however great and brilliant that individual may be. No one was more sanguine as to the future before us than he who has passed away, no one more keen or anxious to secure a successor worthy of himself. I believe, gentlemen, we are on the winning side. Time in all countries and in all ages tells in favour of the demands of the governed being acceded to by those who govern, and we shall not, I hope, have long to wait for a measure of simple justice. Till that time comes we shall, I hope, continue the struggle with all the energy and dogged perseverance which has helped us to build up the largest and most prosperous Medical School in Ireland.

CENTRAL MIDWIVES' BOARD.
MEETING HELD JANUARY 26TH, 1905.

DR. CHAMPNEYS, President, in the Chair.

THE SECRETARY opened the meeting by reading memorials from the Guardians of the Bradford Union and four other Unions, asking the Board to reconsider their decision not to recognise Poor-law Training Schools as such.

Miss WILSON was of opinion that such recognition would be wise, and asked for a special meeting to consider their claims and the best method of bringing them into conformity with every requirement of the Board.

DR. PARKER YOUNG urged that each place should be examined on its own merits and no hard and fast rule made to apply to every Poor-law Institution, and it was agreed *nem. con.* that a special meeting take place.

Several cases of alleged misconduct among certified midwives were read by the Secretary, it being agreed in every case (save one of Police Court conviction) to inquire more fully into details, and no *ex parte* judgment given. In one case, where a certificate had been signed by a medical practitioner, after a midwife had had an illegitimate child, several members contended this sufficient for non-suspension, but Dr. Ward Cousins remarked that it depended on the moral thermometer of the doctor who signed.

Miss WILSON then moved that the following advertisement be issued by the Board:—"Midwives Act, 1902. The Central Midwives' Board requires the services of a registered medical woman, who has acted as house surgeon or physician in a maternity hospital or home possessing an extern department, to undertake from time to time the duties of inspector, at a fee of £1 is. with travelling expenses for each inspection. Particulars and form to be obtained from the Secretary," urging that eleven County Councils had appointed women inspectors. She would suggest that each case of inspection be paid for separately, as this would permit of securing the services of those who were specially competent but not able to give the whole of their time to the work.

DR. PARKER YOUNG wished to substitute "medical practitioner" for "medical woman." The former term would not exclude women. He imagined some men might be better than women; certainly some were as good. Wisdom was not alone in the minds of women, and medical men had had the same experience for the post of inspector.

Miss WILSON replied that the fact of eleven County Councils having appointed women proved they considered them better qualified, especially in the minor details of nursing.

The PRESIDENT inquired what there was which a man could not do, and reminded the speaker that a house surgeon and staff of a hospital maternity department had to see after midwives.

Dr. PARKER YOUNG objected strongly to the term, "medical woman," but was alone in voting against the motion, which was carried, the President not voting, nor Dr. Ward Cousins (who was called away). Miss Paget and Dr. Cullingworth voted for Miss Wilson's motion.

Printed forms of the Examination Scheme, as approved by the Privy Council, were handed round, which we hope to publish in our next issue.

Correspondence.

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

THE GULF STREAM MYTH.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—When, in 1856, I went to Australia as Surgeon-Superintendent of a Government emigrant ship of 1,000 tons, carrying 400 souls, and such voyage lasting 100 days, my little library of science held three treasured books—Herschell's "Preliminary Discourse," "The Admiralty Guide to Scientific Inquiry," and Maury's "Physical Geography of the Sea." I well remember Maury's grand opening, "There is a river in the sea. . ."

Dr. Knott's pleasant and learned essay has not swept from my mind and fancy the old faith or myth that, from the North Cape to Cape Cornwall, the genial climate is in part due to the Gulf Stream.

The conditions involved are cosmic, co-relating with, and dependent on, the motions and energies—so-called laws—of our solar and planetary system.

The earth, revolving on its axis from W. to E., in its equatorial regions, *i.e.*, in its regions of greatest diameter, at the speed of 1,000 miles an hour, leaves its superimposed atmosphere a little behind, and thus we get the flow of wind in the tropics from the east. The cold northerly winds rush towards the region of greatest heat—from 4° to 8° N.L.; thus results the N.E. trade wind. In the Doldrums, or region of calms and greatest heat—4° to 8° N.L.—the trade winds ascend and become upper currents in an opposite direction to the trade wind. At about 30° N.L., these upper currents descend and become our westerly gales, from 30° to 60° N.L.

But observe, that when they descend they have the velocity of the equatorial and greatest diameter of the earth's most rapid rotation. The earth spins on an almost constant and perpendicular axis; thus their super-velocity makes them westerly winds, when they have descended to the higher, slower rotating, latitudes.

It is obvious that from 30° to 60° N. and S.L., the globe has a region of prevailing westerly winds.

Now, just as the tropical atmosphere is left a little in the lurch, to become an easterly wind, so must the tropical ocean lag a little behind, and thus, through the tropics, the whole body of the ocean must have a constant trend from the east to the west. See what has happened; the coast of South America, N.W. of Cape St. Roque, the great hollow of the Gulf of Mexico, the channels between the mountainous Windward Islands have been formed.

This great ocean movement, checked by the mountain ranges of Central America, sweeps round Cape Sable and Florida, and becomes the Gulf Stream.

Dr. Knott will hardly doubt but that the warm waters and atmosphere associated with the Gulf Stream are involved in the great fog region off Newfoundland. But, taking a larger view than that, if a mere "stream," what becomes of this great ocean trend—first easterly, and then, being possessed with the reliquiae of the super-rotation motions of the greater diameter of the entire tropics, finds itself cast back into higher latitudes, which have a less speed of rotation. It must have, in such more slowly revolving

latitudes, a westerly outlet. For the whole inter-tropical ocean is ever, like the trade wind, moving toward the region from St. Roque round the Gulf of Mexico to Florida.

We do not conceive of the Gulf Stream in Maury's poetic words, but that the Atlantic Ocean, from 30° to 60° S. and N.L., has ever an easterly trend, and holding the warm and diffused and super-speeded waters of the Gulf Stream, which sweeps round Florida.

Thus, in the countless ages of astronomical and geological time, have been formed the great fiords of Norway, of the West Coast of Scotland, the West Coast bays of Ireland, the promontory of Cornwall, and the English Channel itself.

I have never supposed that the Gulf Stream reached us like a visible or defined river; but I cannot doubt but that, in its origins, co-relations, and continuity, we in the South and West of Great Britain and Ireland receive the blessings of the Gulf Stream.

One may say, following the old Asiatic philosopher: "There be three things which are too wonderful for me"—(1) The ultimate, yet orderly, modes of bioplasmic reversion in chill and pyrexia; (2) the "modes of motion" imparted to bioplasm by the varied alkaloids; (3) the complex, yet orderly, motions of the winds and seas.

May Dr. Knott live long and help to show us the Keplerian laws of all these three orderly cosmic phenomena!

I am, Sir, yours truly,
WILLIAM H. PEARSE, M.D.ED.

Plymouth.

OUR ENGLISH CLIMATE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The remarks made last week by Dr. Knott on "The Gulf Stream Myths, and Seaside Resorts" were in many ways of interest to those who are anxious to have accurate information on the question of climate. It was rather amusing to read the *Daily Telegraph* on "Our English Climate" (Jan. 26th), and to look at the sunshine map, with the other alongside. Sunshine is now coming up as the prime factor in a "climate," and probably Dr. Knott's flagellation of the Gulf Stream and its mysterious character will bring effects. Of course, the worst part for the Gulf Stream is that the West coast which has been thought to have far the best of it, is very dull on the rainfall map, and with some there is no doubt, however pleasant the sun may be, rain should be avoided.

Probably Dr. Knott is right in his view that the complete disappearance of the Gulf Stream and all the ocean currents in the Atlantic would not have the slightest effect on the weather and climate of Europe. Unfortunately this article in the *Daily Telegraph* has somewhat of an advertising tone about it, and when we see further on that Weymouth is the Naples of England, and such-like panegyrics of a rather hysterical character we may feel disposed to look grave, and not inclined to listen to such treatment of the very important question of climate. If we turn from p. 6 (*D.T.*, Jan. 26th), to p. 11, and just look down at the temperature in Brighton (47°), or Hastings (49°F.), and compare these with Biarritz (59°), or Cannes (61°F.), we can see what is gained by going south in the winter. Those who have travelled much and studied climate carefully are not disposed to regard our climate as a good one. The simple fact of pulmonary diseases being prevalent ought not to be lost sight of, and now that many are migrating to one of our Colonies, very accurate and reliable information should be given in our public papers, so that none may be misled.

I am, Sir, yours truly,

R. L.

London, January 30th, 1905.

STERILISATION OF CERTAIN DEGENERATES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Dr. Rentoul is mistaken if he supposes that a "student of sociology" is necessarily a juvenile. My years, I am afraid, are not less numerous than his.

and I have been a student all my life since my juvenile days. I, and many of us, want to know how Dr. Rentoul proposes in the present state of the law to set about the sterilisation of the vast crowd of degenerates he enumerates and describes, and whose existence we all deplore. Will any proportion of them consent to undergo the operation? Does he propose to lay hands upon them forcibly, to sterilise them, and forcibly detain them until the operation wounds are healed? To do this would be a criminal offence, and in the event of a death from virulent inflammation following the operation, would involve a charge of manslaughter, if not of murder. Moreover, every surviving victim would easily find an enterprising solicitor willing to conduct with the certainty of success an action for damages against the operator. To discuss the law as it applies to surgeons performing operations with or without the consent of patients, under ordinary circumstances, or destroying a foetus to save the life of a mother is not closely to the point, interesting as that subject may be. Sterilisation of degenerates cannot be carried out without special new legislation, and no one with any knowledge of the subject, except perhaps Dr. Rentoul, can suppose that any Government, much less any private member of Parliament, would expose themselves to the ridicule with which such a project of law would surely be received. It seems a pity such a waste of good force on Dr. Rentoul's part should go on, and my object in writing was to try to stop it. Dr. Rentoul says he is a general practitioner, not a specialist. May one without offence suggest for his consideration the ancient maxim—*Ne sutor ultra crepidam?*

I am, Sir, yours truly,

A STUDENT OF SOCIOLOGY.

January 26th, 1905.

Obituary.

DANIEL GIBSON PEARCE THOMSON,
M.D. EDIN.

WE regret to record the death of Dr. Thomson, of Penrith, Cumberland, at the early age of 44 years. He was born at Leith in 1860, and was educated at the University of Edinburgh, where he graduated M.B. and C.M. in 1883, and M.D. in 1897. In 1887 he became assistant to the late Dr. Robertson, of Penrith, and entered into partnership with that gentleman in 1889. Dr. Thomson carried on an extensive general practice with marked ability and success. His early death is a great loss to his widow and six children, and a large circle of patients and friends.

JAMES MUNRO, M.D. ED., J.P., OF BARNARD
CASTLE.

DR. MUNRO, M.D., J.P., was a distinguished student of Edinburgh University, where he graduated in 1859. He was Surgeon-Lieutenant-Colonel to the Durham Militia, Chairman of the Barnard Castle Division of the North Riding and Durham County Bench, and an active supporter of the Conservative party in his own town; the latter frequently entailed lengthy speeches. In later years he conducted a large county practice. His sudden death, from paralysis, is a loss not only to patients, but to medical literature, and to the social and political life of his district.

HENRY WILSON, M.D. ST. AND., M.R.C.S. ENG.,
OF LIVERPOOL.

WE regret to announce the death of Dr. Henry Wilson, which took place quite suddenly, of heart failure, at his residence, Wavertree, Liverpool. He was in his 65th year, and received his medical education at Anderson's College, Glasgow, and qualified M.R.C.S. Eng. in 1863, and L.S.A. the following year. He became M.D. St. And. in 1890. He first started practice in London, whence he removed to Marske-by-the-Sea, where he was appointed Medical Officer to the Earl of Zetland's Ironworks.

THOMAS PERCIVAL, M.R.C.S. ENG., L.S.A., OF
KNOTTINGLEY.

THE death of Mr. Thomas Percival, M.R.C.S., of Knottingley, Yorks., occurred after a few days' illness. He received his medical education at the Leeds School, and obtained the diploma of M.R.C.S. in 1866, and that of L.S.A. in 1867. He carried on an extensive private practice in Knottingley, and held many appointments. He was one of the Vice-Presidents of the Yorkshire Branch of the Incorporated Society of Medical Officers of Health. He has left a widow and five children with whom much sympathy is felt.

Medical News.

Outbreak of Diphtheria.

A SERIOUS outbreak of diphtheria has occurred at Pointon, near Billingham. Several cases have been reported, and two deaths have already taken place. Some grown-up people are amongst those suffering from the complaint. The village had only just recovered from an epidemic of scarlet fever when the first case of diphtheria was notified. The sanitary officials have this week inspected the condition of the parish drain, which in part flows as an open water-course alongside the village street. This is said to be polluted with sewage matter, and is believed to have had something to do with the outbreak.

Influenza Epidemic in North Wales.

SOUTH Carnarvonshire is in the grip of a severe epidemic of influenza. Over fifty people are being medically treated in the Pwllheli district, and hundreds are down in Portmadoc and Crickieth. Several schools have been closed. The schools at Pentre, Brynteg, Brymbo Vron, Gweryllt, and Cross Street, in the Wrexham district, have been closed on account of an epidemic of influenza.

The Royal College of Surgeons.

The ceremony of conferring the Honorary Fellowship of the Royal College of Surgeons in Ireland on Dr. Traill, Provost of Trinity College, will take place in the College, Stephen's Green, on the evening of Saturday, February 11th, at 7 o'clock, in the presence of his Excellency the Lord Lieutenant. Subsequently the Earl of Dudley and the Provost will be entertained at dinner by the President and Fellows of the College.

International Anti-Alcohol Congress.

THE tenth International Anti-alcohol Congress will be held at Bucharest this year from September 12th to 17th. Among the questions proposed for discussion are the Sunday closing of public-houses and drinking saloons.

Conjoint Examinations in Ireland.

CANDIDATES have passed the supplemental Final Examination as undernoted—(Winter Session, 1905):—Francis Lyndon Bradish, Eugene Aaron Bernard, Charles Paget O'Brien Butler, Frederick James Cairns, Douglas Edward Crosbie, James Stuart Dunne, Jennette Carroll Hargrave, Patrick Mary Moore, Reginald Anthony Murphy, Donald De Courcy O'Grady, Martin O'Keefe, William Sheehen.

THE Royal Dental Hospital, Leicester Square, has received a donation of £100 from the Worshipful Company of Goldsmiths.

THE annual meeting of the German Association for Scientists and Medical Practitioners is to be held this year at Meran from September 24th to 30th.

THE foundation-stone has been laid of a convalescent home for aged Frenchmen at Brighton. The home will be carried on in connection with the French Hospital in London.

THE second French Congress of Climatotherapy and City Hygiene will be held at Arcachon on the 24th to 29th of April next. The President is Professor Renant, of Lyons. The work of the Association is divided into various sections. Those interested in the subject can obtain any desired information of the General Secretary, M. C. D. Festal, Villa David, Arcachon.

Notices to Correspondents, Short Letters, &c.

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

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.

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 re-forwarding 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.

THE CIRCULAR PRESCRIPTION.

A consultant physician writes to tell us of a postal packet sent to him by the Dead Letter Office. It contained a letter of thanks from a young lady to a former patient thanking him for the use of his prescription, and saying she had carefully followed all directions. The prescription was much battered and creased and countersigned by chemists, evidently in the result of many previous journeys of a similar kind. The patient in this case was a barrister. From a gentleman named as an intellectual profession one might have looked for better things. Obviously to use one prescription for many patients is to court disaster. Our correspondent says his first impulse was to send the whole packet off at once to his former legal patient—but on second thoughts he relegated it to the waste paper basket. The incident illustrates the fetish worship of prescriptions often evinced even by so-called educated people.

W. E. F.—The gentlemen you addressed is out of town for several weeks, but your letter will be given him on his return. We hope to hear from you often in your new capacity.

MEDICAL EDITORS IN GLASS HOUSES.

Sir.—In your "note" in yesterday's issue under the above heading (p. 94) occurs the following, "It is not easy to see on what grounds a medical Editor can cry 'Maranatha' to a medical man," etc. This, I presume is a mistake for "Anathema," *accused* (a not uninfrequent mistake), whereas "Maranatha" means "Our Lord cometh." The E.V. rightly separating the two words by a full stop.

Yours faithfully, H.S.
[We thank our correspondent for calling attention to an obvious slip.—Ed.]

Meetings of the Societies, Lectures, &c.

WEDNESDAY, FEBRUARY 1st.

OBSTETRICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8 p.m. Annual Meeting. Specimens will be shown by Mr. Targett, Mr. Handley, Dr. F. E. Taylor, and Mr. Bland Sutton. Short Communications.—Dr. E. W. H. Groves: A New Operation for the Cure of Vaginal Cystocele. The President (Dr. Mallins): Annual Address.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. P. G. Freyer: Clinique. (Surgical.) 5.15 p.m. Mr. A. W. M. Robson: Pancreatic Cysts and Pancreo-lithic Calculi.

CENTRAL LONDON THROAT AND EAR HOSPITAL (Gray's Inn Road, W.C.).—5 p.m. Demonstration.—Mr. S. Low: Oral and Laryngopharynx.

THURSDAY, FEBRUARY 2nd.

ROENTGEN SOCIETY (20 Hanover Square, W.).—8.15 p.m.—Messrs. Newton and Son will show Dr. T. Holland's X-Ray Diaphragm Compressor. Paper.—Dr. C. A. Wright: Some Points in the Construction of a High Frequency Machine (accompanied probably by some novel exhibits).

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

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Dr. T. W. Eden: Acte's Torsion of the Pedicle in Pelvic Tumours.

MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST (7 Fitzroy Square, W.).—5 p.m. Lecture: Dr. J. E. Squire: "Murmurs" not dependent on Diseases of the Heart. (Post-Graduate Course.)

FRIDAY, FEBRUARY 3rd.

SOCIETY OF ANÆSTHETISTS (20 Hanover Square, W.).—8.30 p.m. Exhibition of Ethyl Chloride Inhalers before and after the meeting. Papers: Mr. Wade: On the Presence of Ethyl Chloride in Commercial Chloroform.—Mr. B. Hird: Ethyl Chloride in Eye Practice, with an account of a Fatality.—Dr. Barton: Continuous Administration of Ethyl Chloride in operations about the Upper Air Passages (followed by discussion to be opened by Dr. McCardie).

WEST KENT MEDICO-CHIRURGICAL SOCIETY (Royal Kent Dispensary, Greenich Road, S.E.).—8.30 p.m. Paper:—Dr. Annis: Immunity against Disease.

LARYNGOLOGICAL SOCIETY OF LONDON (20 Hanover Square, W.).—5 p.m. Cases and Specimens will be shown by Mr. O. A. Parker, Dr. F. Spicer, Mr. P. de Santi, and others.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. R. Lake: Clinique. (Ear.)

NATIONAL HOSPITAL FOR THE PARALYSED AND EPILEPTIC (Queen Square, Bloomsbury, W.C.).—3.30 p.m. Dr. Batten: Nerve Terminations in Muscle.

TUESDAY, FEBRUARY 7th.

NORTH-EAST LONDON CLINICAL SOCIETY (Tottenham Hospital, N.).—4 p.m. Dr. Chappel: Clinical Medicine.

Bacancies.

Monmouthshire Asylum, Abergavenny.—Junior Assistant Medical Officer. Salary £150 per annum, with board, lodging and washing. Applications to the Medical Superintendent.

Craig-Leith Poorhouse and Hospital, Edinburgh.—Medical Officer. Salary £100 per annum, with board, and apartments. Applications to And. Ferrier, Clerk, Parish Council Chambers, Castle Terrace, Edinburgh.

Brompton Hospital for Consumption and Diseases of the Chest.—Assistant Resident Medical Officer. Salary £100 per annum, with board and residence. Applications to the Secretary.

East London Hospital for Children, and Dispensary for Women, Shadwell, E.—Pathologist and Registrar. Salary £100 per annum. Applications to Thomas Hayes, 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.

Leeds General Infirmary.—Resident Medical Officer. Salary £100 per annum, with board, residence, and washing. Applications to the Secretary.

Bolton Infirmary and Dispensary.—Junior House Surgeon. Salary £100 per annum, with furnished apartments, board and attendance. Applications to the Hon. Secretary, W. W. Cason, Esq., 20 Mawdale Street, Bolton.

Manchester Children's Hospital, Pendlebury.—Lady Superintendent. Salary £100 per annum, with board, rooms, washing, and attendance. Applications to the Secretary at the Hospital, Pendlebury.

Lewisham Union.—Medical Officer. Salary £180 per annum. Applications to H. C. Mott, Clerk to the Guardians, Union Offices, 286 High Street, Lewisham, S.E.

Sunderland Infirmary.—House Physician, House Surgeon, Assistant House Surgeon. Salary £100 per annum, with board, residence and washing. Applications to the Secretary.

Rochdale Infirmary.—Resident Medical Officer. Salary £100 per annum, with board, residence, and washing. Applications to Henry Booth, Secretary, 58A York Street, Rochdale.

Somerset and Bath Lunatic Asylum, Wells Somerset.—Medical Superintendent. Salary £100 per annum, with furnished house and allowances. Applications to John Coates, Clerk to the Visiting Committee.

Egyptian Government—Ministry of Public Instruction.—Professor of Pathology and Bacteriology at the School of Medicine, Cairo. Salary £800 per annum. Applications to the Director, Government School of Medicine, Cairo, Egypt.

Township of Manchester.—Assistant Medical Officer. Salary £110 per annum, with furnished apartments, fire, light, and attendance. Applications immediately to James Macdonald, Clerk to the Guardians, Poor-law Offices, New Bridge, Manchester.

North of Ireland.—B. C. Doctor for a good practice. D., Dublin Office of this paper. (See Advt.)

Hydropathic Establishment.—Resident Physician. Applications to J. Adams and Son, 17 Merrion Row, Dublin. (See Advt.)

Navy Medical Department.—Three Dental Surgeons for Portsmouth, Plymouth and Chatham. Salary £1 per diem and traveling expenses when necessary. Applications to the Director General, Medical Department of the Navy, 18 Victoria Street, S.W. (See Advt.)

Appointments.

AMNOT, THOMAS ENGELHART, M.B., B.S., Durh. House Surgeon to the Dorset County Hospital, Dorchester.

ATKINSON, J. P., M.R.C.S., L.R.C.P.Lond. Certifying Surgeon under the Factory and Workshop Act for the Lynton District of the county of Devon.

BENNETT THOMAS M.B., Ch.B., Glasg. House Physician to the Derbyshire Royal Infirmary.

Marriages.

LIAS—CARVER.—On Jan. 27th, at St. James's, Piccadilly, Francis James Lias, of Yokohama, Japan, to Marian Elizabeth, only surviving daughter of the late Edmund Carver, Esq., M.D., of Cambridge, and of Mrs. Carver, "Barramotee," Torquay.

Deaths.

DOBIE.—On Jan. 27th, at 63 Woodbury Park Road, Tunbridge Wells, Edward John Dobie, Captain, R.A.M.C., aged 33 years.

FRANCIS.—On Jan. 29th, at Allstrass, St. Julian's Farm Road, West Norwood, Melina Anna, widow of the late Surgeon-General Charles Richard Francis, M.B. of H.M. Indian Army, aged 76.

SUTTON.—On Jan. 30th, at Dharmasala, Punjab, suddenly, Margaret the beloved wife of S. W. Sutton, M.D., Medical Mission, C.M.S.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

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No. 6.

Original Communications.

UTERINE DISPLACEMENTS. (a)

By ARTHUR E. GILES, M.D., B.Sc.Lond.,
F.R.C.S.Ed.,

Gynaecologist to the Tottenham Hospital; Assistant Surgeon,
Chelsea Hospital for Women.

GENTLEMEN,—I shall confine my present remarks to the consideration of certain points in the symptoms, diagnosis, and treatment of two forms of displacement—namely, Retroversion and Prolapse.

RETROVERSION.

With this I shall include retroflexion, because the two conditions are very frequently associated. Without entering into the question of the causation, I may say that, broadly speaking, retroversion depends on conditions outside the uterus, and especially relaxation of ligaments; whilst retroflexion is rather due to conditions inherent in the uterus, and perhaps mainly to want of tonicity in its musculature.

Symptoms.—Some doubt has been expressed as to the possibility of symptoms being produced by retroversion pure and simple, by which I mean a retroversion that is not complicated by endometritis, hyperplasia of the uterus, or prolapse or inflammation of the ovaries and tubes. Experience leads me to hold the view that an uncomplicated retroversion is capable of producing symptoms, and does so in a minority of cases. At the same time I readily concede that in most of the cases in which symptoms arise they are due to some associated condition. I have met several cases in which a retroversion caused reflex disturbances, such as nausea and vomiting; and the relationship was demonstrated by the immediate improvement which followed replacement of the uterus, and by a return of the symptoms when the retroversion recurred. In other cases an uncomplicated retroversion has just as constantly been accompanied by distressing backache, which reposition of the uterus relieved.

In most cases in which a retroversion has existed for a little time, a degree of hyperplasia supervenes, due to the chronic congestion to which the displaced organ is subjected; and endometritis with erosion of the cervix may be added. Backache then becomes a constant symptom, accompanied by a feeling of weight in the pelvis, causing lassitude. A more or less profuse leucorrhœa adds to the patient's discomfort. The symptoms are liable to be accentuated at the menstrual periods, and the quantity of blood lost becomes increased, till it merits the term menorrhagia. Then another factor is introduced—namely, prolapse of the ovaries and tubes; they share in the congestion, become swollen and tender, and the patient complains of pain on intercourse, and aching pains referred to the iliac regions. The sequence of events that I have just given in outline is a frequent one; but in some cases endometritis is an initial condition, and the displacement is secondary. The general health usually becomes

affected after a time; the feeling of lassitude and the readiness with which the patient becomes tired lead to an indoor, invalid life; the tendency to constipation, from which so many women suffer, becomes increased, and in a vicious circle adds to the already present congestion of the pelvic organs. Hæmorrhoids form a not uncommon complication; they are due partly to constipation and partly to direct pressure of the bulky uterus on the rectum. Here, then, we have a picture which, because it is so common, we may regard as drawn from life.

Diagnosis.—In most cases the diagnosis of a retroversion is one of the easiest things in gynaecology; yet there are some pitfalls which lead to mistakes being made in a rather surprisingly large proportion of cases. In the first place mistakes arise because a retroversion is diagnosed from the position of the cervix, instead of from the position of the fundus. It is true that we usually find that when the fundus is retroverted the cervix points forwards, lying in the axis of the vagina instead of being at right angles to it (Fig. I). But in a case of acute anteversion, the cervix may lie pointing forward and yet the fundus may be lying quite forward also (Fig. II). On the contrary, a cervix pointing backwards is usually associated with a fundus in the normal position (Fig. III); but in a case of acute retroflexion the fundus may be lying in the pouch of Douglas, whilst the position of the cervix is not appreciably affected (Fig. IV). Then, again, an erosion limited to the posterior lip of the cervix is rather characteristic of a backward displacement of the uterus; and one on the anterior lip alone is usually associated with normal anteversion; but if we attempt to diagnose the position of the uterus by looking through a speculum we shall fall into errors such as I pointed out when speaking of the position of the cervix. The third fallacy is due to the assumption that a rounded swelling felt behind the cervix, in the pouch of Douglas, is necessarily the body of the uterus. It is so, in most cases; but on the other hand we may have to do with a small tumour, ovarian or fibroid, lying behind the uterus (Fig. V); or the swelling may be due to a collection of fluid, to a tubal pregnancy, or to prolapsed and inflamed appendages.

Lastly, we must not assume that there is a backward displacement because we do not feel the body of the uterus lying behind the pubes. It is to be remembered that the normal uterus is a very mobile organ, possessing a considerable normal range of movement in an antero-posterior plane; and sometimes the fundus is found neither quite forward nor quite back, but in an intermediate position, with its long axis parallel with the long axis of the body (Fig. VI). This is called "Retroposition."

The moral of all this is that in making a diagnosis of retroversion we must not be guided by the position of the cervix alone; nor must we draw hasty conclusions from any solid body felt behind the cervix; nor from the absence of a solid body behind the pubes. We must be guided by the bimanual examination, in order to determine *where* the fundus actually is; and when we call something behind the cervix the fundus, we must be quite sure that the fundus is not actually elsewhere.

(a) An Address delivered at the North-East London Post-graduate College, Tottenham.

The cases that present the greatest difficulty in diagnosis are those in which two or more swellings are found, one of which occupies the pouch of Douglas. All we can be sure of, on digital examination, is that one of the these swellings is the uterus. Here we receive the greatest possible assistance from the use of the sound. If the point of the sound passes forwards, leaving the swelling in the pouch of Douglas untouched, it is evident that the latter is a tumour or one of the swellings previously mentioned; on the other hand, if the point of the sound passes backwards into the swelling, this must be the fundus, and the swelling felt in front is the non-uterine one. There is only one condition in which the following out of the rule here given may still lead to a mistake, and that is such a rare condition that it hardly counts. I refer to a case of double uterus, of the type of uterus didelphys, in which one

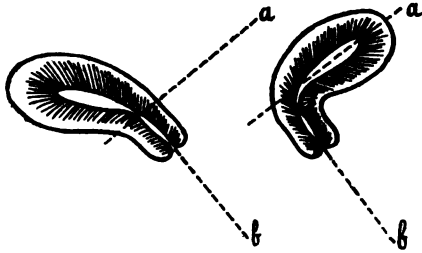


FIG. I. a Normal axis of the uterus. b Axis of the vagina.

FIG. II.

half of the uterus might be lying back, whilst the other half pointed forwards. Perhaps the greatest difficulty of all is found in a case where there is reason to suspect early pregnancy, and the passage of the sound is consequently contra-indicated. We may then have to wait for the assistance of time in making a diagnosis.

I shall defer what I have to say about treatment, so as to consider the treatment of both forms of displacement together. I therefore pass on to the second form of displacement.

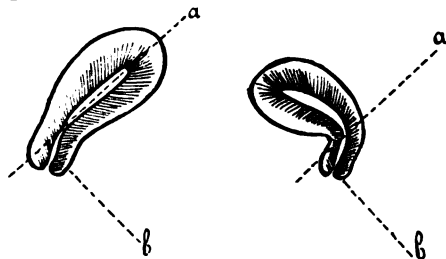


FIG. III.

FIG. IV.

PROLAPSE.

With this condition I shall include procidentia, inasmuch as the latter may be regarded as a later and more pronounced stage of prolapse. With procidentia it is not merely a question of the uterus coming lower down so as to protrude from the vulva; there is also in nearly every case a varying degree of hyperplasia, affecting especially the supravaginal portion of the cervix. This has an important bearing on the question of treatment, as we shall see later on.

Symptoms.—In the early stages of prolapse the symptoms are almost identical with those of retroversion. As a matter of fact, there is nearly always some degree of retroversion to start with. And so we find the patient complaining of backache, pain in the lower abdomen, a feeling of weight and dragging in the pelvis, with the accompanying lassitude and lack of energy. When the uterus is lying in the lower part of the vagina with the cervix almost if not quite presenting at the vulva, there is a "bearing-down" feeling, a sensation of a foreign body to be expelled from the vagina. This degree of prolapse is frequently accompanied by some bulging of the vaginal walls, especially the anterior; and this gives rise to frequency of micturi-

tion, owing to bladder irritation. The next stage is that in which a considerable portion of the uterus and the vaginal walls is forced outside the vulva when the patient is straining or even standing; as the vaginal orifice becomes more and more stretched, the hernia becomes more and more constant, until the patient may have considerable difficulty in returning the uterus. It is a remarkable fact that patients generally appear to suffer less discomfort when the uterus is completely outside the vulva than when it is lying low in the vagina; I suppose that the sense of something to be expelled is what gives the most discomfort. Whatever the explanation may be, it is certain that we not infrequently find women who have gone about with apparent nonchalance for months or years with the uterus and vagina outside the body; and doubtless some who come for advice would have done without

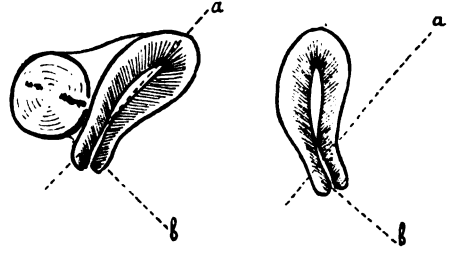


FIG. V.

FIG. VI.

even longer, were it not that a new symptom is apt to come on, namely, bleeding. This results from ulceration of the everted vaginal walls, due to friction against the clothes; with the bleeding there may be some discharge from the raw surfaces; and alarm at the occurrence of bleeding or repugnance for the soiling of the clothes with discharge will lead the patient to seek advice, though the presence of a large hernial mass between the legs was apparently a matter of indifference.

Diagnosis.—Nothing could be simpler than the diagnosis of prolapse and procidentia. The uterus is

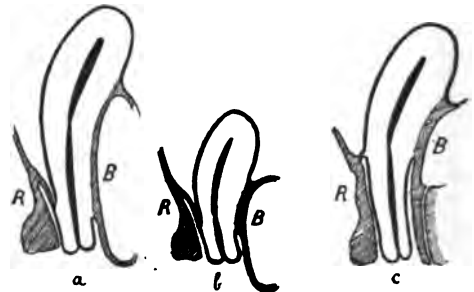


FIG. VII.

a Hyperplasia of the supravaginal portion. b Prolapse. c Hyperplasia of the vaginal portion. B Bladder. R Rectum.

found low down in the vagina, or lying outside, as the case may be. In the recumbent posture, however, a prolapse may not be evident unless the patient be caused to strain, or "bear down" as the midwives phrase has it. Of course, the prolapse will also be manifest if the patient be examined standing up; but it must be remembered that if a woman be caused to strain in the erect posture a certain amount of prolapse might be diagnosed in the healthiest woman. By adopting this procedure a certain notorious woman quack made much wealth in Manchester in my student days. She first gave free lectures to "women only," when she took the opportunity of inviting her audience to visit her at her rooms. As a result, an incredibly large proportion of healthy women were found to have prolapse, for which the lady-professor had an unfailling remedy in the form of a special pessary, which was charged for in a ratio suited to the gullibility of the patients.

Although the diagnosis of prolapse is so easy, there are nevertheless several important points to be borne in mind. The first is that behind the prolapse, and causing it, there may be some pelvic tumour; this will readily be discovered on reducing the prolapse, when the pelvis will be found to be unduly occupied. In the second place, prolapse of the uterus must be distinguished from hyperplasia of the cervix, of which it will be remembered that there are two forms, according as the hyperplasia affects the vaginal or the supravaginal portion of the cervix. The difference between prolapse and the two forms of hyperplasia is that in the former the fundus lies low down in the vagina, whilst in hyperplasia the fundus will be found in its normal position, and the uterine cavity will be found considerably lengthened. Another point of difference between prolapse and hyperplasia of the vaginal portion is that in the latter case the vagina is of normal length, though the cervix may be presenting at the vulva. This distinction does not hold in the case of hyperplasia of the supravaginal portion, because there the vaginal vault is carried down with the cervix, just as it is in prolapse. A glance at Fig. VII will show the relation of the parts in these three conditions.

Some other conditions might conceivably be mistaken for prolapse, namely, inversion of the uterus and a fibroid extruded from the cervical canal; but there would be but little ground for such a mistake, inasmuch as the part that presents in prolapse is the cervix; whilst in the other cases it would be a rounded body in which no aperture corresponding to the external os would be found.

Treatment.—In considering a retroversion there are three courses open to us. We may leave it alone, we may support the uterus with a pessary, or we may fix it in position by operation. Each course is the proper one under certain conditions, and we have now to consider what those conditions are.

A Retroversion should be left alone in nearly every case in which it causes no symptoms; and especially when the patient is unmarried, or is approaching the menopause.

A Retroversion should be treated by means of a pessary in some cases in which it causes no symptoms—namely, in married women, where the displacement is unfavourable to conception. In uncomplicated cases in which the displacement, although causing symptoms, may be regarded as a temporary phase, a pessary is proper treatment; for instance, in young married women who may be expected to conceive, and in women who have recently been confined. When retroversion is complicated by hyperplasia the best plan is to first employ depletory treatment by means of hot douches and glycerine tampons, and then adapt a pessary. When endometritis is present, treatment by means of a pessary should be preceded by curetting. Whenever the uterus is freely movable, and there is no disease of the appendages, a pessary should be tried as the first step in treatment, that is, before contemplating any operation for its fixation.

A word or two as to pessaries. It must be remembered that it is absolutely useless to insert a pessary unless the uterus can first be brought into proper position. Speaking generally, a ring pessary is of very little use for retroversion; some modification of the Hodge pessary should be used. The kind that I have found give the best results is the Braxton Hicks type, with a thick posterior bar.

The effective scope of pessaries is distinctly limited, because they are positively contra-indicated in cases in which there is a uterine tumour or any inflammatory disease of the vagina, uterus or appendages, and in my opinion they are also contra-indicated in cases in which there is good reason to believe, or experience of them for some time has shown, that the retroversion cannot be cured by this means and that the patient will have to continue wearing the pessary for an indefinite number of years.

A Retroversion should be treated surgically whenever it is complicated by adhesions fixing it in a faulty position, and in all cases in which the retroversion is a minor

feature of the case, for example, when there are uterine fibroids, ovarian tumours, or diseased appendages. Cases of old standing, complicated by hyperplasia and endometritis, should be first curetted and then treated radically by ventro-fixation. When pessaries have been tried for some time and there appears to be no prospect of the uterus retaining its position unaided, surgical measures should be adopted. In the future, we shall probably regard the practice of compelling a patient to wear a pessary for eight or ten years or more, with the necessity thereby entailed of frequent manipulations and examinations, as a relic of barbarism, and, indeed, some of us are inclined to take this view even now. And this is especially the case in those not infrequent instances in which, although a pessary is worn, it fails to keep the uterus in its proper position, and the state of the patient may be described as one of modified discomfort.

I may say a few words about the different surgical procedures that have been recommended and adopted for the cure of retroversion. The first was Alexander's operation for the shortening of the round ligaments, an ingenious procedure which apparently has given good results in its originator's hands, and in the practice of some others. It has been but little heard of for some years, having been superseded by other operations. Probably the reasons for its not taking a permanent place in the treatment of displacements were, first, the fact that the round ligaments were not always well enough developed to be of service, and were not always easily found; secondly, the fact that it was not possible to examine at the same time the conditions of the appendages, or to free adhesions if present; thirdly, some uncertainty of results. The next step was the opening of the abdomen, and the suspension of the uterus by sutures to the peritoneum or the abdominal wall; but while this allowed of free examination of the pelvic organs, and retained a considerable degree of mobility of the uterus, it had the drawback that the peritoneum was not resistant enough to hold the uterus up, and the displacement nearly always returned. Then some operators, apparently determined that the uterus should at any rate remain fixed to the abdominal wall in a position of marked anteversion, sutured it to the fascial and muscular layer of the abdomen by numerous sutures passed through the fundus and posterior surface of the uterus. The results were excellent, in that there was no return of retroversion; but if any patient subsequently became pregnant, disaster followed in the form either of early abortion or of serious and sometimes even fatal complications at the time of delivery. Dührssen then proposed vagino-fixation, of which various minor modifications were introduced by other surgeons; the results were not very satisfactory as regards the return of displacement, and numerous cases were recorded in which complications occurred during pregnancy and labour. The operation never came much into favour in England, and it is not often heard of now. Meanwhile, there were some who felt that some form of abdominal hysteropexy would prove to be the best plan after all; if, they said, the fixation were more secure than it is in ventro-suspension, and yet not so rigid as in the plan of fastening up the uterus by its posterior surface, a happy mean might be hit upon. And so they passed the sutures low down on the anterior surface of the uterus, and carried them through the peritoneum and fascia of the abdominal wall. This is the plan which I have practised now for several years, and the results have been highly satisfactory; as far as I know, there have been only two cases in which the retroversion has returned, out of over eighty cases of ventro-fixation. You will ask, however, what happens when patients become pregnant? Well, by the plan adopted, the fundus of the uterus, which is the part chiefly involved in the enlargement of pregnancy, is left free to expand as it will. Some six of my cases have become pregnant after ventro-fixation, and there has not been any complication during labour. One of them miscarried, but she became pregnant too soon in my opinion—namely, within a few weeks after operation; and this

is one of the two cases in which the displacement recurred.

I have by no means enumerated all the operations devised for retroversion. I may incidentally mention the plan of the vaginal shortening of the round ligaments; that of a modified Alexander's operation, in which the inguinal openings are enlarged to allow of a digital examination of the ovaries and tubes; and that of the intra-abdominal shortening of the round ligaments, of which again there are several modifications. In my opinion, ventro-fixation is the best surgical procedure for the treatment of retroversion.

It only remains now for me to speak of the treatment of prolapse. This differs from retroversion in that while some cases of the latter displacement can quite well be left alone, every case of prolapse requires treatment. The simplest plan is by means of pessaries; and here the rubber ring pessary is usually the best. In a certain proportion of cases a cure may be effected, because when the uterus has been kept in position for some time, its ligaments may regain some of their tone, and it will then remain in proper position without a pessary. This is especially the case when the patient is approaching the climacteric; for then the process is aided by the natural contraction of the vagina and atrophy of the uterus incidental to the menopause. But if there seems a prospect that pessaries will have to be worn for many years, surgical treatment is indicated; and this will nearly always be the case when the perinæum has been torn, or the vulvar orifice greatly stretched. Indeed, this factor may play such an important part that a ring cannot be worn at all, because the vaginal orifice gapes so much that a pessary cannot be retained. Obviously the proper treatment in such a case is to narrow the vaginal outlet by means of the operation of perineorrhaphy. This will at least permit of a pessary being retained, if so desired. But patients sometimes ask whether, if they are to have an operation, they cannot have something done to cure the prolapse altogether, and save them the perpetual annoyance of pessary treatment. Fortunately, the answer is in the affirmative; at the same time that the perineorrhaphy is done, the uterus can be attached to the anterior abdominal wall by ventro-fixation; and there are few operations of election that give more satisfactory and even brilliant results. Sometimes a ventro-fixation alone is done; but in many cases the results of this are disappointing if the perinæum is deficient; and I have long since come to the conclusion that if a prolapse is treated surgically, the two procedures, ventro-fixation and perineorrhaphy, should be done at one sitting. There is one important point to be taken into consideration when such a step is contemplated—namely, the hyperplasia which nearly always accompanies prolapse. I said, when first speaking of prolapse, that this hyperplasia had an important bearing upon treatment. If a prolapsed and hyperplastic uterus be treated by ventro-fixation, the cervix will probably still be so low in the vagina as to cause considerable discomfort, and give the patient the idea that the operation has been a failure. So the proper procedure in these circumstances is to first reduce the hyperplasia by keeping the patient in bed for one or two weeks if possible, and by carrying out depletory treatment by means of glycerine tampons and hot douches. This will often reduce the length of the uterus by an inch or more. If the uterus fails to respond sufficiently to this treatment, or if circumstances will not allow of its being carried out, then the best plan is to dilate and curette the uterus, amputate a portion of the cervix, repair the perinæum, and then open the abdomen and secure the fundus to the abdominal wall. This should be done at one sitting, in the order given. In conclusion, let me say that in the surgical treatment of displacements, whether retroversion or prolapse, we must not hesitate to combine several procedures in one operation. We must consider the various factors concerned, not only the displacement, but also the endometritis, the deficient pelvic floor, and the elongation of the cervix, if one or more of these complications be present. Curetting,

perineorrhaphy and ventro-fixation can all be done in one case in half an hour if we do not spend the time in gossip or in "playing about." This principle of thoroughness will enable us to cure our patients, the adoption of more casual methods will result in a proportion of failures.

LATERAL CURVATURE OF THE SPINE:

THE IMPORTANCE OF EARLY RECOGNITION WITH A VIEW TO SUCCESSFUL TREATMENT. (a)

By SIR LAMBERT H. ORMSBY, M.D., F.R.C.S.,
Ex-President, Royal College of Surgeons, Ireland; Senior Surgeon
Meath Hospital and County Dublin Infirmary.

THE importance of early recognition of spinal curvature is seldom realised, although at the initial stage almost all cases can be successfully treated.

Those who devote special attention to this branch of surgery are aware of the ignorance that exists regarding it. Schoolgirls, at the plastic ages, between ten and fifteen, are allowed to assume all kinds of awkward attitudes while sitting at desk and table, piano and typewriter,



FIG. I.

and when in bed to contort their bodies into abnormal shapes, yet it is well known that long-continued posture in one position is certain sooner or later to induce trouble, if not permanent deformity.

Mothers, governesses, nurses, who have special charge of young boys and girls, should examine the children periodically, stripping them to their hips and putting them through a careful and minute inspection, so as to assure themselves that no deviation of the spine from the normal condition is present. Having paid considerable attention to this subject and examined many hundreds of cases, I invariably have to say to the parents, when seeing such a case for the first time—"When did you first notice this curvature? It is a very great pity that you allowed it to run

(a) Being the substance of a Clinical Lecture delivered at the Meath Hospital and County Dublin Hospital.

on so long, as the longer it has existed the greater will be the harm done, and the more tedious and more difficult the treatment."

Another difficulty to be contended with is the reluctance of parents to understand that treatment, to be successful, must be carried out in a hospital, under the surgeon's own personal supervision and daily observation. With regard to the time necessary for the successful treatment and cure of any case, it is simply impossible to fix any date.

Many friends of patients, either from want of means or disinclination to part with their children for a term, have recourse to the instrument-makers, who will furnish a special mechanical support, which encourages vain hopes that it is effecting a cure, whereas it is only covering up and hiding the mischief.

Many a fine handsome young girl is allowed to grow up with an ever-increasing deformity,



FIG. II.

her friends not noticing anything wrong till, perhaps, the dressmaker, fitting a frock, accidentally discovers that the two sides of the back do not correspond. This perhaps is the first time anything wrong has been discovered, although the curvature must have existed for many months, and then the surgeon's aid is sought at a time when the treatment will be necessarily tedious, whereas were it discovered six months earlier it would most likely have been short and certainly far less complicated.

In early cases of lateral curvature, before any osseous rotation has taken place in the bodies of the vertebrae, and when the curvature is merely due to muscular contraction with ligamentous relaxation, a sojourn of a few weeks or couple of months in a private or public hospital is advisable, where a well-equipped gymnasium is attached, with all the modern forms of appliances constructed for the remedial rectification of all forms

of spinal curvature. With this object in view, I have had fitted up and attached to the National Children's Hospital, Harcourt Street, Dublin, such a gymnasium, and have secured the services of a drill sergeant, well skilled in all forms of gymnastic exercises, who attends when required and instructs the different classes of patients repairing there for treatment. Even in cases where no actual curvature exists, such physical exercises are found most beneficial for the general improvement and muscular development of the *physique*.

The girl whose physical training is neglected always stoops. Stooping shoulders invariably contract the chest, and the flat-chested girl does not, as a rule, know how to breathe. She may say she breathes like everybody else, but if she has a narrow chest and stooping shoulders she certainly cannot breathe healthfully and legitimately. And, again, what is more to be desired and admired than an erect and graceful carriage in walking? Yet how few do we encounter in the streets who can be said to possess it! Everybody knows that those who have been trained to walk can cover double the ground with ease of those who shuffle along with head and body poked forward. An easy and vigorous gait is an accomplishment which no one ought to dispense with, and a contorted and contracted framework must necessarily impair, in the long run, the organs within. Fig. I shows a case of lateral curvature in a young girl of 13, where the curvature had existed only about three months, and where the treatment was very brief and successful. Fig. II shows a case of a youth of 16, where the curvature had existed for twelve months, and where the treatment was very long and tedious, although ultimately successful.

ON THE NATURE OF FRIEDREICH'S ATAXIA. (a)

By HARRY RAINY, M.D., F.R.C.P.Ed.

THE clinical features of the disease might be summarised as (1) an unsteady, reeling gait, and indecision in performing fine movements; (2) static ataxia and an irregular nystagmus, the latter being of importance in the diagnosis from locomotor ataxia; (3) choreic and athetoid movements; (4) slurred monotonous speech; (5) the development of deformities of the feet and spine; (6) such sensory phenomena as dulling of cutaneous sensibility and subjective sensations of pain or itchiness; (7) the mental condition may be normal, but defective intelligence, dementia, &c., are not infrequent; (8) the deep reflexes are abolished, but the knee-jerks may escape if the lesion does not extend so low as the third lumbar segment. Among the chief diseases with which Friedreich's ataxy might be confounded (but from which careful consideration of the above features usually enable the observer to differentiate it) were chorea, tabes, multiple sclerosis, cerebral syphilis, cerebral tumour, cerebellar ataxia, certain developmental anomalies, and hysteria. The greatest difficulty arises in connection with hereditary cerebellar ataxy, which one might almost say formed one of the two types (Friedreich's ataxia being the second) in which hereditary ataxia has gradually been

(a) Read before the Edinburgh Medico-Chirurgical Society, January 18th, 1905.

differentiated. Similar though the two probably were, both in their nature and origin in a developmental imperfection, and though intermediate cases occurred, it was better, both from a clinical and pathological standpoint to maintain a distinction between them. The following is a summary of the morbid changes observed in the case examined:—(1) In many of the peripheral nerves, especially of the lower limbs, the nerve fibrils had disappeared and their places were occupied by interstitial tissue. Similar changes were present in the cauda equina, limited here, however, to the sensory roots. Through an accident the posterior root ganglia were not available, but since the nerve elements were affected on both sides of them, it may be presumed that they were implicated. (2) The posterior columns of the cord were affected from the sacral segments upward, the degenerated areas corresponding to the root lesions, while endogenous tracts escaped except in so far as they were secondarily involved by contiguity to affected parts. (3) In the upper dorsal region some of the posterior roots were only partially affected, and there was a corresponding escape of fibres in the cord above this level. (4) The lower cervical nerves and their prolongations into the cord were markedly degenerated and replaced by interstitial tissue, but some of the upper cervical roots had escaped. (5) There was marked degeneration of the direct lateral cerebellar and crossed pyramidal tracts. The change in the latter had as its upper limit the level of the decussation—a fact also observed by Dr. Ormerod in a case which he examined. The lesion in the crossed pyramidal tract therefore begins where the spinal type of vascularisation commences, and where the tract comes into relation with the direct lateral cerebellar tract. (6) The direct pyramidal tract, the cells of the anterior cornu, and the motor nerve roots are normal. The sensory tracts above the nuclei of Goll and Burdach were unaffected, and its cerebrum and cerebellum were normal. The new interstitial tissue of the cord was of neuroglial origin; both in the posterior and lateral columns it often had a whorled appearance, suggestive of a common cause for the degeneration in both these positions. Where the change was most advanced the interstitial tissue was densely felted together, and tended to invade, and strangle the nerve fibrils in, neighbouring tracts. Amyloid bodies—according to Robertson and the author, degenerated mesoglia cells—were abundant in the degenerated areas. (7) The cord as a whole was smaller than normal at the level where degeneration was most marked. (8) The vessels, pial septa, and pia mater were normal, as also were the cerebellar peduncles. From his study of the case Dr. Rainy drew the following conclusions as to the pathology of Friedreich's ataxia: (1) A typical case of long standing may show no changes in the brain or cerebellum, hence lesions of these structures are not a necessary part of the pathology of the disease. (2) The similarity of the lesions in the lateral and posterior tracts justifies the belief that they have the same cause. (3) The cause is probably an inherent defect in the nerve elements. (4) The primary change is probably a disappearance of nerve elements, possibly due to defective myelin production or deficient longevity. (5) The nerve structures are replaced by neuroglia, first arranged in fibrils, then assuming a whorled appearance, and finally becoming a dense felted

mass. (6) The degeneration of the direct cerebellar tract may either depend on its own imperfect vitality or on alteration in the cells of Clarke's column. In this region, few healthy cells were found, but much stress cannot be laid on this appearance in a Müller hardened specimen.

We thus see how Friedreich's ataxia differs from other forms. In tabes, poisons conveyed by the lymph stream destroy the more sensitive nerve elements and stimulate the less vulnerable connective tissue. In cerebellar ataxia the lesion is nearly related in nature to that in Friedreich's disease, but its localisation is different; yet from contiguity, and from inherited nature of both diseases, mixed cases are but to be expected.

The Out-Patient Departments.

WEST END HOSPITAL FOR DISEASES OF THE NERVOUS SYSTEM.

Case of Disseminated Sclerosis of the Irregular Type, exhibiting a remarkable period of Latency.

By FREDK. S. PALMER, M.D., M.R.C.P.;

Assistant Physician to the Hospital.

H. J., æt. 35, unmarried, an army pensioner from the R.A.M.C., came to the out-patient department of the West End Hospital for Nervous Diseases on November 30th, 1904, under the care of my colleague, Dr. T. Outterson Wood, who very kindly passed him on to me.

The patient, a strongly-built man, 5ft. 5ins. in height, and weighing 12st. 1lb., gave the following history of himself:—He joined the Army in November, 1895, and eight months later (July, 1896), when acting as assistant ward master in the Military Hospital at Norwich, he was suddenly seized with an attack of vomiting, almost continuous for a week, and lasted at intervals for a fortnight; dimness of vision, and palpitation, followed soon afterwards by stiffness in the movements of both legs, but chiefly in the right; facial paralysis and external strabismus on the right side, with dull, aching pain at the back of his neck. From these initial symptoms he gradually, and apparently almost completely, recovered in from two to three months, and was passed for service in Egypt and South Africa. His habits have always been strictly temperate, although on more than one occasion lately he has been suspected of alcoholism from the peculiarity of his gait. He denies syphilis, but admits gonorrhœal infection five years ago. When serving in South Africa he had enteric, with one relapse at Johannesburg, and was in hospital for four months. On recovery, after a month's sick leave spent at Durban, he resumed his duties and continued to discharge them until February, 1904. Ever since the onset of his illness in 1896, he has been subject to transient attacks of vertigo, and has felt very nervous, more particularly when spoken to. For the last three years, he has had precipitate-micturition with some degree of incontinence and constipation. Eighteen months ago he began to complain of a dull pain over the sacral region which he attributed to rheumatism, and has never ceased. For the last twelve months he has experienced difficulty in rising from a chair, pains like cramp in both legs, and progressive difficulty and fatigue in walking. He has never had any sharp lightning pains in the limbs, girdle sensations, or crises since the gastric attack in 1896.

On examination, it was noticed that he walked with a staggering cerebello-spastic gait, and that his speech is slightly slow and drawing. Both pupils are equal, and react to light and accommodation. No nystagmoid movements are detected on lateral deviation. His vision is 6-36 with the right eye and 6-12 with the left, the difference being apparently due to a small nebula on the right cornea from three attacks of ulceration, presumably non-syphilitic. The temporal halves of both discs are markedly atrophic. All the other cranial nerves are normal, including both

divisions of the seventh. There is slight inco-ordination in the right arm, but an entire absence of volitional tremor. His knee-jerks are brisk, especially the right, which almost amounts to a clonus. The ankle-jerks are obtained, and there is a short, badly sustained clonus on the left side. The plantar responses are typically extensor on both sides. There is no definite Rombergism, nor any evidence of muscular atrophy. He complains of paræsthesia—numbness and tingling in both legs and the right arm, but no objective sensory changes can be discovered; tactile sensation and muscle sense are normal. The sphincters are affected; increased frequency and precipitate micturition; there is also some incontinence, and he is still very constipated. The cardiac sounds and impulse beat are normal, and his urine contains no trace of albumin or sugar. The features of interest in the case are briefly—

1. The absence of many of the so-called cardinal signs of the typical disease—nystagmus, intention tremor, and marked speech defects.

2. The sudden onset and marked severity of the initial symptoms. The patient states he was nearly blind for two or three weeks at Norwich, but before he resumed his duties his vision was nearly restored.

3. The remarkable period of latency or remission of the symptoms which enabled him to discharge his military duties, and even to take part in two exhausting campaigns, the second after an attack of enteric fever, although it is obvious that his recovery from the initial lesion was never complete.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON.
MEETING HELD JANUARY 27TH, 1905.

The President, DR. FREDERICK TAYLOR, in the Chair.

MR. P. LOCKHART MUMMERY (introduced by MR. C. T. DENT) showed an Instrument for Examining the Rectum and the Sigmoid Flexure, and Drawings of Lesions seen through it. The instrument was a slightly modified Strauss' sigmoidoscope, by which a diagnosis might be made, so avoiding exploratory laparotomy.

MR. JONATHAN HUTCHINSON, jun., showed a Case of Extensive Syphilitic Necrosis of the Skull, causing an Intra-cranial Abscess, but without any Cerebral Symptoms. The man contracted syphilis at the age of eighteen, and was treated for a short while. Four years later he had rupia with severe pain in the joints, also iritis and posterior synechia in the left eye, and the treatment was resumed. He then remained free from symptoms for ten years, until September, 1904, when a lump formed on the vertex, followed by sloughing of a circular patch of scalp, then by necrosis of the skull beneath until the cerebral pulsations appeared, but the man was, meanwhile, able to work as a letter carrier, suffering neither from headache, giddiness, nor other cerebral symptoms until his admission to hospital. There the dead bone was removed by trephining, and a large sub-cranial collection of pus found between the skull and the dura mater.

DR. EASTES asked what treatment was proposed.

MR. FAGGE was of opinion that the drainage was imperfect, seeing that the internal area of necrosis was usually so extensive in these cases.

MR. HUTCHINSON, in reply, said that the case originally appeared to be a periosteal gumma which had softened and could be scooped out by the finger. He proposed to wait until the sequestrum was loose; as operation in this stage involved the danger of infecting some neighbouring vein.

MR. C. H. FAGGE showed a case of Uretero-lithotomy for Calculus. The patient was a girl, æt. 7, who, in 1901, had pain in the right loin with hæmaturia. In 1903 the same symptoms returned, and again in September, 1904, this time with a tender spot two inches to the right of the umbilicus; and under an anæsthetic a small, hard

mass could be felt. A calculus was found in the ureter about one inch below the kidney, which appeared normal. The calculus was removed, and the ureter and abdominal wall sutured. Healing followed, and the urine became normal a week after the operation.

MR. DOUGLAS DREW thought that, in all cases of ureteral calculus, the kidney should be explored for two reasons; first, the frequency of a renal stone being co-existent with the ureteral, and secondly the frequency of pyelitis, which needed draining.

DR. PARKES WEBER showed a case of Localised Flushing and Sweating on Eating, which, together with "strizæ patellares," followed appendicitis ten years ago. The symptoms had persisted since the former exhibition of the patient in October, 1897. When he began to chew solids a patch of redness immediately appeared on the left cheek, and the skin sweated. When this was at its maximum a smaller and less marked patch might appear in front of the right ear. Vinegar and water in the mouth, also mastication movements of the jaws, called forth the appearance to a less marked degree. Swallowing did not produce the phenomenon. After ceasing to chew, the sweating, and then the redness, slowly disappeared. The strizæ patellares were well marked, like the lineæ albicantes gravidarum, and were attributable to the flexed position of the knees when suffering from appendicitis.

DR. WEBER thought that an important factor, apart from the long illness—several months—was the great rapidity with which the boy grew at the age of sixteen. He asked for information on the effect of febrile illnesses on lineæ gravidarum.

SIR DYCE DUCKWORTH commented on the frequency of the occurrence of the lineæ after typhoid. He had published in this Society's "Transactions" a very marked instance of that, in which pains preceded the atrophy. Lineæ gravidarum certainly occurred in robust health, and he saw no reason for the introduction of any other factor than pressure.

MR. MCGAVIN said that the condition should be seen often in tuberculous ankylosed joints if Dr. Weber's explanation held.

DR. WEBER, in reply, pointed out that a continued pyrexial disease, gravely affecting nutrition, differed greatly from a local joint condition.

MR. CHARLES R. KEYSER showed a Case of Gottre in a boy, æt. 5. A lump appeared in the neck in September, 1904, with anorexia, occasional vomiting, and malaise. The swelling appeared to be a parenchymatous gottre, and increased to the size of a hen's egg. The boy had always lived in London, and no other member of the family had been similarly affected. The tumour rapidly diminished under treatment by iodine and iodide internally, and mercury iodide externally.

MR. CHARLES R. KEYSER showed a Case of Recklinghausen's Disease. The man, æt. 38, had all his life a number of small, rounded, subcutaneous tumours, which were steadily increasing in number. He said that one brother was similarly affected, and that his mother died of the disease. The tumours were all soft and absolutely painless, there were two areas of pigmentation on the trunk, but there were no signs of malignancy nor of nervous disease.

DR. BATTY SHAW asked for Mr. Keyser's definition of von Recklinghausen's disease. He had shown a similar case on the previous night at the Harveian Society, in which nerve tumours, an essential part of the disease, were present.

MR. MCGAVIN referred to the relation between the disease and malignancy. He knew of a case where multiple fibro-sarcomata had developed.

DR. WEBER wished to know whether any of the tumours had been microscopied.

SIR DYCE DUCKWORTH said that the case shown was an ordinary one of molluscum fibrosum. Dr. Fagge had given an excellent account of these cases, and had described various complications such as gastric dilatation and mental defects.

MR. KEYSER, in reply, said that Dr. Walsham, in

1899, had described a spindle-celled sarcoma of the neck, which had pressed on the brachial plexus. Mr. Alexis Thompson had collected a series of cases in which sarcomatous degeneration had supervened. He defined Recklinghausen's disease in a broad manner, and held that many varieties, of which his case was one, existed. The three most important features were subcutaneous nerve tumours, molluscum fibrosum and pigmentation. He had not removed any of the tumours, because such a procedure often led to increased growth and even to sarcomatous degeneration. The commonest mental defect was a stammer. Diarrhoea was frequent in these cases, but he did not know of the occurrence of gastric dilatation.

Dr. BATTY SHAW showed two cases of Acromegaly. One was in a man, *æt.* 36, in whom enlargement of the fingers and hands had been noticed for four or five years, numbness and tingling for three years. A radiogram of the hand showed the changes in the phalanges. Eight or nine years ago the patient wore No. 6 boots, now No. 8, the great toe was markedly enlarged and the skin thicker. The skull had enlarged, the eyelids were thickened, the nose broadened, the wrinkles on the face deepened, the voice hoarse, but the eyes and vision were normal, and there was no kyphosis. The patient was sometimes troubled by headache and by drowsiness. The other was in a woman, now in the Brompton Hospital for Consumption under Dr. Habershon, with disease of the left chest. The hands and fingers had enlarged, also the feet, the malar eminences were prominent, the lower lip protruded, also the eyelids, giving a heavy, dull expression. The tongue was enlarged. The patient suffered from headache, insomnia, and morning vomiting, but there were no eye symptoms. Photographs and radiographs further illustrated the case and distinguished it from pulmonary hypertrophic osteo-arthropathy. The skull radiograph showed the sella turcica distinctly, with a light area above it.

Dr. BATTY SHAW showed Bilateral Wasting of the Subcutaneous Tissues of the Face in a boy, *æt.* 10. This had commenced after the age of 2½. Three years ago he attended the Victoria Hospital for Children, and the wasting became more marked after measles two years ago. The wasting appeared to affect the subcutaneous tissues, not the skin, muscles, or bone. The condition was bilateral. There was no muscular paralysis nor wasting in any other part. The patient had had no illness, except some slight rheumatic symptoms and choreic movements.

Mr. W. G. SPENCER showed a boy, three years after Removal of a Large Cystic Adenoma of the Left Kidney. In the summer of 1901, when the boy was *æt.* 12, the mother had first noticed the swelling, but she said he had always had a "big stomach." In January, 1902, the boy was first taken to Dr. Redmond Roche, who diagnosed the case. Abdominal nephrectomy was done by a T-shaped incision; some vascular adhesions to the diaphragm caused a temporary disturbance of respiration. The half of the specimen in the Westminster Hospital Museum was shown, and Mr. Shattock's description of the other half in the College of Surgeons Museum was appended.

Mr. JONATHAN HUTCHINSON, jun., commented on the occurrence of a congenital cystic disease, which was usually bilateral and complete, in one kidney only and in only part of that. In the general cases, partial removal of the disease was quite justifiable. He had done this with success in one instance.

Mr. W. G. SPENCER showed a child after Recovery from Infantile Paralysis of the Deltoid. When the subject of nerve-grafting for such cases was before the Society in October last, the girl was in Dr. de Havilland Hall's ward, and could not then raise the arm from the side at all. The child had been kept under Dr. Hall's observation, and had had the arm rubbed and electricity used. She can now raise it easily above the head and seems to be recovering well.

Mr. C. H. FAGGE asked for the period between the onset and the beginning of recovery.

Dr. WILFRED HARRIS gathered that the affection followed an injury to the arm, and not an acute illness; this cast doubt on the diagnosis. The question of nerve grafting should not be entertained until reaction of degeneration had been present for at least three months, as recovery in these cases was so variable.

Mr. SPENCER admitted that the paralysis followed on an injury. What we wanted to know in these cases was which were going to recover and which not.

Dr. F. E. BATTEN showed a child with Graves' Disease and Myxœdema at the age of ten. A fat child, with a pale, puffy face and hands, squeaky voice, and placid, slow manner, had considerable thyroid enlargement and a pulse-rate between 118 and 140; also a waddling gait. Other signs of nervous or visceral disease were absent. Thirteen weeks ago the child fell downstairs; eleven weeks ago headache came on with such severity that the child had to be kept in bed; six weeks ago disturbance of gait came on.

SIR DYCE DUCKWORTH showed a case of Xanthoma Diabeticorum. The patient, a clerk, *æt.* 23, had diabetes in September, 1904. A sister died of the disease, *æt.* 31. He had been first of all treated privately, then at St. Thomas's Hospital, and was admitted to St. Bartholomew's in December. On December 24th a large number of small papules appeared over both elbows. The papules were hard, shotty, and a small amount of yellowish material could be pressed out. On the 31st the papules had increased in size, and fresh ones appeared symmetrically over the back, buttocks, knees, and scantily on the face. On January 25th the papules were increasing in size and number. Amount of urine averages 100 oz. per diem. Sp. gr. 1034. Perchloride of iron reaction present. Sugar on admission 25 gr. per ounce; on January 25th 12 gr. per ounce. Body-weight on admission 8 st. 6 lbs.; on January 25th, 7st. 8 lbs.

SIR DYCE DUCKWORTH commented on the extreme rarity of this condition. It hardly ever occurred apart from diabetes, though it had been recorded in diabetes insipidus. It was commoner in males. The remarkable feature in his case was the very sudden onset when under observation. The condition was certainly not due to glycœmia, but probably to some other toxic substance; Dr. Luff had suggested β -oxybutyric acid.

Mr. EDRED M. CORNER showed a Case eighteen months after Fracture of the Scaphoid, Semilunar, and the Cuneiform Bones of the Carpus. The hand had been caught in a printing machine and twisted. He was told at a hospital that the injury was a dislocation, and was treated with splints. Weakness and deformity persist. A skiagraph showed that the semilunar bone had been comminuted, and the fragments displaced forwards; so also the scaphoid, except the radial portion, which remained in position. The portion of the cuneiform nearest the radius had been fractured. The distal row of carpal bones was displaced backwards.

ROYAL ACADEMY OF MEDICINE IN IRELAND. SECTION OF MEDICINE.

MEETING HELD FRIDAY, JANUARY 20TH, 1905.

SIR J. W. MOORE in the Chair.

PARATYPHOID FEVER.

Dr. PARSONS read notes on three cases of continued fever in which for some time the diagnosis was obscure. They all occurred in the same building and about the same time. The first proved to be a severe case of typhoid fever, and gave a definite Widal with Eberth's *Bacillus typhosus* on the twelfth day of the illness. The pyrexia lasted for fifty days. Case II, though tested on three separate occasions by different strains of *Bacillus typhosus*, gave no reaction, but gave very definite clumping with Gärtner's *Bacillus enteritidis* on two occasions, and with different strains. The pyrexia lasted twenty-one days. Case III was also negative with *Bacillus typhosus*, but positive with Gärtner.

The pyrexia lasted fourteen days. In all cases the subjective phenomena were headache and malaise. The objective signs were temperatures of 102° to 104° F., while the average pulse was only 90. In none of the cases was the spleen palpable, and only in No. 1 were any spots visible. Cultures were made from the urine and faeces in the latter cases, but the *Bacillus enteritidis* was not isolated. Dr. Parsons referred to cases of paratyphoid reported in *The American Journal of Medical Science*, and pointed out the necessity for isolating various strains of paratyphoid bacilli, against which the blood of obscure cases of continued pyrexia might be tested. Owing to the general absence of ulceration in paratyphoid fever, he was of the opinion that the diet need not be quite so rigid as in typhoid fever.

Dr. CRAIG described minutely the fatal case of paratyphoid which he had seen. He admitted the man from his dispensary, who was then looking very like typhoid. His temperature was 103.2°, pulse 100 and respirations 24. He had three liquid yellow motions and developed a rash, which at first consisted of rose spots, but later became dark, like typhus. The tongue was thickly coated, cerebation slow, and he refused food. The abdomen was distended. He became delirious, and seventeen days after the rigor which had ushered in the illness he died. The pulse averaged 95 to 100, and respirations 24. The spleen was easily noted to be enlarged. *Post-mortem* there was no evidence of enlargement or ulceration of Peyer's patches, the greater part of the ileum was in a state of acute inflammation. Dr. White examined the blood on the fourth day after admission. He tried a Widal, and got clumping with a dilution of 1 in 25. There was no evidence of Eberth's bacillus, but one of the forms of *Bacillus enteritidis* had caused the illness. In a number of cases hæmorrhage from the bowel had been observed.

Dr. TRAVERS SMITH said he had seen two cases which he thought were paratyphoid. One was a woman, æt. 32. On admission her temperature was 103°, pulse not markedly quick, no diarrhoea, enlarged spleen, nor rose spots; but there was great abdominal distension, and she was rather livid. The blood was negative to Widal. She died in about a week, and *post-mortem* there was no trace of disease in Peyer's patches, nor was the spleen enlarged. In the other case the tongue was coated, spleen a little enlarged, pulse rather quick, and the temperature up. The blood was negative to Widal. The fever gradually subsided; but for ten days the spleen remained large, then it subsided, and she got perfectly well. He suspected paratyphoid, but had no proof of it, as the special blood reaction had not been tested for.

Dr. MELDON thought that in paratyphoid one should be just as careful with regard to diet as in typhoid, as in some cases there had been hæmorrhages, showing disease of the intestine. The presence of a large ulcer had been reported in one case.

Dr. FANNIN said he had had a case of a boy, æt. 17, who had a continued fever, the characters and course of which were the same as typhoid. There were no rose spots nor enlarged spleen. He had acute laryngitis. At that time Widal was negative. Ten days after the temperature had become normal a relapse occurred. It followed a typhoid course, the laryngeal symptoms were renewed, rose spots appeared, and the spleen became palpable. He became very ill, and was removed to hospital. Two or three days afterwards symptoms of perforation occurred. An operation was performed, and a perforated ulcer discovered, but the patient did not recover. Dr. Thompson was satisfied that the ulcer was like an ordinary typhoid one. In that case, then, repeated examinations of the blood had failed to give the Widal reaction. The course of the illness resembled typhoid, and a fatal result occurred after perforation, therefore it was possible that some forms of paratyphoid could have the definite ulceration of Peyer's patches.

Dr. KIRKPATRICK said he would like to ask whether any differentiation had been made in the clinical history

of the fevers which were due to the different groups of paratyphoid bacilli.

Dr. McWERNY discussed the cases from a pathological point of view. He said that one would be inclined to call Dr. Parsons' second and third cases, cases of Gärtner infection. It had been mentioned that the blood serum failed to agglutinate typhoid, but did Gärtner's bacillus. That carried an indication of Gärtner infection, which was not quite the same thing as paratyphoid. The Gärtner bacillus was not quite the same type as the alpha and beta groups of paratyphoid, but presented certain differences. It was quite possible that the second and third cases were paratyphoid, but the bacilli would have had to be isolated and their characters fully tested. What he found lacking in the pathological description was a statement of the different dilutions which were employed.

Dr. PARSONS, during his reply, said that intestinal lesions had been mostly found to be in abeyance during paratyphoid, and thought it was not so necessary to restrict the diet as in typhoid. There was no difference in the clinical course of the fevers produced by the alpha and beta groups. In his communication he had used the term paratyphoid in its widest sense, and had included Gärtner's bacillus in the term, although he was aware that there was a tendency to restrict the term to a small group of bacilli.

TWO CASES OF LARGE WHITE KIDNEY.

Dr. PEACOCKE described the clinical history of two cases which had been recently under his care. The symptoms of each case were very similar, and were, briefly—anæmia, universal dropsy, diarrhoea, and scanty, highly albuminous urine, containing numerous casts. The kidneys were found to be macroscopically large white kidneys; but, microscopically, while both showed some increase in connective tissue, one was found also to show commencing amyloid degeneration. He discussed the causation of chronic parenchymatous nephritis, and was in favour of regarding the disease as originating always in a previous attack of acute nephritis. The cases described as chronic from the beginning were either cases in which the acute attack had been overlooked or were examples of lardaceous degeneration. He considered the best classification of diseases of the kidney associated with albuminuria was as follows:—(1) Nephritis, acute and chronic; (2) granular kidney; (3) the kidney of lardaceous disease.

Dr. McWERNY.—With regard to the microscopic specimens, the impression he got from those of the second case was that it was far from certain whether it was really amyloid degeneration or hyaline. The section showed hyaline change of a portion of the glomeruli, but there was no differential staining to show whether there was also amyloid change. The question might have been answered by seeing whether the middle coat of some of the smaller arteries was affected in the same way, but he had failed to see this change. Therefore, he was inclined to think it was hyaline degeneration. The other section also showed hyaline changes in the glomeruli, but not to the same extent. A pathologist would diagnosticate the second case as early chronic interstitial nephritis.

Dr. TRAVERS SMITH said that his experience went to show that chronic parenchymatous nephritis was insidious in onset. The history of the onset was often misleading. One saw a good many cases of acute nephritis occurring during scalatina; he had never seen these cases coming back suffering from chronic parenchymatous nephritis, and he did not think it could be common. One of Dr. Peacocke's cases exemplified the difficulty of diagnosticating a mild acute case from chronic parenchymatous nephritis, and this was a serious question from a prognostic point of view. In both you might have extensive dropsy, the quantity of urine diminished, hyaline and epithelial casts, blood—all this made it very difficult to come to a diagnosis, particularly in those cases where there was no antecedent cause, such as scarlatina.

Dr. KIRKPATRICK said that in examining micro-

scopic sections of kidney disease it was very important to examine all the fields carefully and to make large sections. When large portions were examined, although they differed in one part from another, yet many of the kidneys had various points in common. A classification thus became possible; but he thought that any classification based on histology alone was unsatisfactory. All of these diseases were more or less of the nature of inflammations, and the effect of the inflammation was evident in one in the parenchyma, in another in the interstitial substance. There were many cases where the differences were so pronounced that one was justified in putting them into different classes; but when one examined further the changes were completely progressive, and from the most typical acute nephritis to the most well-marked chronic case there was no distinct breach of continuity on microscopic examination.

Dr. WHITE said that he had had an opportunity of applying the special tests for amyloid substance to the sections, and found that a small portion was really amyloid, though the major portion was hyaline.

Dr. DRURY said he did not know that he could agree with the statement that many cases of chronic parenchymatous nephritis resulted from acute. He had been for a long time trying to find *bona fide* acute cases which turned into chronic, but had never found them. He thought that many of the cases of chronic nephritis, secondary to acute, were really chronic cases in which acute exacerbations had come on during already existing disease. You had to know the history beforehand. He thought that Dr. Peacocke was inclined to lay too much stress on amyloid change as being the primary cause of many chronic tubular cases.

Sir J. W. MOORE quite agreed that chronic parenchymatous nephritis seldom followed on scarlatinal nephritis, which was usually followed by complete recovery. With regard to causes, he did not hesitate to assign alcohol as of prime importance, though various causes co-operated, as cold and damp. He also thought the mode of death was important in these cases. The toxæmia was comparatively infrequent in very dropsical cases, whereas in the other cases it was very likely to cause death. The heart was really the crucial point in the management of nephritis, for as long as it could compensate there was some chance of the patient getting on.

Dr. PEACOCKE, in his reply, said that the cause of death in both cases was nothing very definite. Asthenia was the best term to use for it. In these acute cases which developed into chronic there was often an interval of some months before the latter symptoms came on. He did not agree that the symptoms of amyloid disease were so apparent that you could always come to a diagnosis. He believed that amyloid change did occur even when there was not much suppuration. There was no doubt that very often in those cases which were described as chronic parenchymatous nephritis and large white kidney, there was marked amyloid change.

LIVERPOOL MEDICAL INSTITUTION. MEETING HELD JANUARY 19TH.

Dr. JAMES BARR, President, in the Chair.

Dr. W. BLAIR BELL exhibited and demonstrated the use of the following instruments:—(1) Combined peritoneum forceps and wound retractor; (2) complete infusion apparatus, with improved venous cannula.

Mr. ROBERT JONES and Dr. DAVID MORGAN presented an analysis and radiographic illustrations of sixteen cases of bony deposits following dislocation of the elbow-joint under their observation. These deposits had followed simple dislocation, unaccompanied by fracture, and were not associated with myositis ossificans progressiva. They differed from myositis ossificans due to local irritation, and their occurrence in presence of a fracture was not associated with callus display. The periosteum was believed to be the origin of these bony deposits. A series of radiographic lantern

slides depicted their growth, from slight shadows to dense bony formation. The diagnosis and prognosis were discussed, and microscopic slides shown to demonstrate their true bony nature as distinct from calcareous changes.

Mr. W. T. CLEGG read notes of a case of CEREBELLAR ABSCESS which occurred as the result of acute ear trouble. The clinical history of the case was given, and the different diagnosis between temporo-sphenoidal and cerebellar abscess discussed. An operation had been performed, but without relief to the patient. At the autopsy a large abscess was found in the right lateral lobe of the cerebellum, the infection having travelled from the ear along the sheath of the auditory nerve. There was no meningitis.

Mr. CLEGG also related a case of acute labyrinthitis in a child, 2 years and 8 months of age, in which the symptoms closely resembled those of meningitis. After recovery, deafness persisted. There had been no discharge from the ear.

Dr. NATHAN RAW read a paper on "Some Points in the Diagnosis and Treatment of Typhoid Fever," based on an observation of 362 cases treated in hospital during the last sixteen years. He referred in detail to the great difficulties in diagnosis which many cases presented in the early stages of the disease, and discussed the value of Widal's reaction as an aid to the practitioner. Hæmorrhage and perforation were the two most formidable complications, and a careful *resumé* of the symptoms of perforation of the intestine was given, as it was highly important to be able to diagnose its immediate onset, so that prompt operative measures might be adopted. In his opinion, the treatment of the future would be directed towards reducing the virulence of the bacilli and the onset of toxæmia, on the lines suggested by Professor Wright, or by the introduction of a serum. The cold or continuous bath treatment undoubtedly in other countries gave better results than any other, but he believed it would be some considerable time before it was generally adopted in this country in the treatment of typhoid fever.

Dr. W. CARTER considered Bieger's suggestion of feeding patients suffering from typhoid fever with pure peptones good, and he had carried it into practice for many years. Commenting upon Widal's reaction, he mentioned two cases in which it proved misleading.

Dr. W. B. WARRINGTON considered that even when made with much care, the serum reaction was not devoid of ambiguity, and the observer was from time to time left in doubt as to the positive or negative nature of the reaction.

Dr. N. E. ROBERTS was of opinion that the mortality of enteric fever in Liverpool, when treated in hospital under modern conditions, would average about 12 per cent. He based this on his experience of close upon 2,500 cases treated at the city hospitals since 1892. The mortality of this disease is greatly influenced by the class of patient under treatment, and, as illustrating this point, Dr. Roberts said he had never lost a nurse or any member of the hospital staff from enteric fever at the Grafton Street or Parkhill Hospitals since he joined these institutions in 1892.

The President, Dr. J. Hill Abram, Dr. T. R. Bradshaw, Dr. A. G. Gullan, Dr. C. J. Macalister, Dr. R. S. Archer, and Dr. R. J. M. Buchanan also took part in the discussion.

NORTH-EAST LONDON CLINICAL SOCIETY. CLINICAL MEETING HELD THURSDAY, FEBRUARY 2ND, 1905.

Dr. R. MURRAY LESLIE, President, in the Chair.

THE following cases were exhibited:—

Dr. A. J. WHITING showed an infant, æt. 6 weeks, with Congenital Hypertrophic Stenosis of the Pylorus. The child was manifestly ill, and some abdominal distension had been observed over the stomach. Vomiting was frequent and had persisted, off and on, ever since

birth. The bowels were constipated. A rectal examination revealed nothing abnormal.

Mr. HERBERT CARSON considered that intestinal obstruction could be excluded. He recommended most careful watching, and that lavage should be practised for the first few days. If at the end of a short time improvement did not set in, the advisability of operative measures might then be thought of.

Dr. G. P. CHAPPEL thought that the condition of the pylorus after taking food should be observed. He would be inclined to give a more prolonged trial to washing out the stomach.

Dr. CHAPPEL also showed a case of Abdominal Tumour in a little girl, *æt.* 2½. A provisional diagnosis was suggested of sarcoma of the kidney with a secondary deposit in the omentum. The swelling had been noticed for three months.

Dr. J. W. HUNT thought the case was one of renal tumour, most probably a hydatid.

The PRESIDENT showed two cases of Pneumothorax, one in a man the subject of phthisis, in whom the condition had practically cleared up. The other case was one of Hæmo-pneumothorax, which had been previously exhibited before the Society. A recent exploration with the syringe revealed the fact that the blood was slowly becoming absorbed, its place being apparently taken by clear serum.

Dr. D. FOGARTY remarked that the latter patient had been under his care since his discharge from the hospital. He had been taking suprarenal extract together with potassium iodide, and his whole condition had certainly much improved.

Dr. NORMAN MEACHEN exhibited a girl, *æt.* 15, the subject of Cheilitis associated with a Localised Hyperidrosis affecting the central parts of the face. The upper lip was swollen and the mucous membrane was chronically inflamed, the condition having lasted for one year. Her mental condition was somewhat dull. There was a well-marked tuberculous family history. The opinion of the exhibitor was that the lip was strumous in character.

Dr. F. J. TRESILIAN (Enfield) showed a man, *æt.* 44, with a large tumour at the back of the neck. He had had it for two years, and he said that he found it somewhat useful for carrying weights upon! The swelling was spherical, of a semi-solid feel, with an ill-defined sense of fluctuation, and was about ten inches in circumference.

Mr. CARSON considered that the tumour was of the same nature as a wen, and that it would most probably be found to consist of a soft, fibromatous and vascular tissue.

Dr. R. MURRAY LESLIE also showed a girl with right-sided hemiplegia in whom recovery was slowly taking place.

Dr. D. McASKIE showed a man, previously exhibited before the Society, the subject of Leukæmia. The X-rays had caused great diminution in the volume of the spleen. He now presented a bronzing of the skin, chiefly attributable to arsenic which he had been taking at the same time.

The following pathological specimens were exhibited

1. Dr. E. HOOPER MAY: A Perforated Duodenal Ulcer. The chief interest lay in the unusual clinical features of the case. The patient was a child, *æt.* 12, in whom the symptoms began with vomiting and diarrhœa. There was practically no pain in the upper part of the abdomen. The appendicular region was first explored at the operation, but her condition became so grave that nothing more could then be done.

2. The colon from a case of Pre-Natal Intestinal Obstruction.

3. Dr. C. R. SALISBURY read notes of a case of Tuberculous Testis that he had removed by operation.

4. Dr. C. E. HUTT showed an infant with a large Meningo-Encephalocele which had caused some difficulty as regards the diagnosis of the presentation. The child lived an hour after its birth.

5. Dr. W. H. PAINE exhibited a specimen of the so-called Intra-Uterine Amputation, together with skiagraphs illustrating the condition.

6. Dr. CHAPPEL showed the brain from a case of cerebral hemorrhage, causing left-sided hemiplegia without aphasia in a woman.

THE SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

MEETING HELD ON FRIDAY, JANUARY 20TH, AT 11 CHANDOS STREET, W.

DR. PERCY LEWIS (Brighton) in the Chair.

Mr. F. JAFFREY showed two cases of Volkmann's Contracture, which had occurred in the right forearms of two girls, *æt.* 2 and 7, as a result of fractures. In each instance the splints had produced pressure sores. He was in favour of lengthening the flexor tendons by operation.

Dr. W. H. KELSON showed a boy, *æt.* 6, from whom he had successfully removed a fibrous growth on the right vocal cord. On recovering from the anæsthetic, the voice was found to be clear. He also showed a boy, *æt.* 12, whom he had treated by the galvanocautery for lupus of the epiglottis and left vocal cord, the voice returning. The upper part of the epiglottis was wanting and its stump had been covered with red papules. The ventricular bands, left vocal cord, and anterior commissure were similarly affected. There was no history of syphilis, no evidence of lung disease, and no tubercle bacilli in the sputa.

Dr. L. GUTHRIE showed a girl, *æt.* 12, whom he brought before the Society in December, 1903, as a case of aortic stenosis. He was still of the opinion that the physical signs indicated aortic disease and thought that there might be some congenital malformation in the neighbourhood of the aortic valves. The girl was highly rheumatic. As on the former occasion, various opinions were expressed on the physical signs and the conclusions to be drawn from them. The lack of unanimity was somewhat remarkable.

Dr. A. MORISON showed a boy, *æt.* 10, with marked Double Aortic Disease and Mitral Regurgitation. There was an indefinite history of rheumatism.

Dr. C. CARPENTER showed a child with Congenital Pulmonary Stenosis and probably a Patent Septum Ventriculorum. The child had come under his care for an attack of catarrhal jaundice.

Mr. DONALD ARMOUR brought forward a boy, *æt.* 4, with a Peno-scrotal form of Hypospadias, with a view to eliciting the opinion of members of the Society as to the best kind of operative treatment and the best age at which to carry it out.

Dr. E. PRITCHARD showed a girl, *æt.* 6, to illustrate hæmophilia, hereditary in the male line for two generations, and evidenced in the third in a severe form in a female. The child had suffered from severe attacks of epistaxis since babyhood. Her father and grandfather were affected, but no other members of the family. He also showed a boy, *æt.* 14, with Congenital Ptosis of the left eyelid.

Mr. G. PERNET showed a case of Generalised Lichen Planus, of three months' duration, in a boy, *æt.* 6. The boy had a "tower skull," ptosis with absence of the upward movements of the eyes, and a highly arched palate. He also showed a child, *æt.* 4 months, recently vaccinated, with a Circinate Gyrate Erythema Multifforme.

Dr. J. G. EMANUEL (Birmingham) showed a most remarkable specimen of Congenital Multiple Occlusions of the Small Intestines, from a seven months' infant, who died nine days after birth. The child had vomited since birth; but no stool had been passed. As the result of an enema a large motion of meconium was passed. There was complete atresia of the bowel at the duodeno-jejunal juncture, the duodenum being much hypertrophied and dilated, being larger even than the stomach. In two other places the jejunum was completely absent for about half an inch. In five other places, in the jejunum and upper part on the ileum, the gut was completely occluded by annular

constrictions. There were no signs of intra-uterine peritonitis.

Mr. A. T. MARSHALL showed a specimen of a collar stud impacted in the œsophagus and perforating the trachea. It was removed *post-mortem* from a female infant, æt. 7 months. It had produced consolidation of the right lung, ulceration into the trachea an inch above the bifurcation, and pus in the trachea and œsophagus.

The cases were discussed by Drs. Percy Lewis, W. Ewart, L. Guthrie, F. J. Poynton, H. Skelding, C. W. Chapman, R. Hutchison, A. Morison, Edmund Cautley, G. A. Sutherland, C. O. Hawthorne, Mr. Donald Armour, and Mr. G. Pernet.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, February 5th, 1905.

TREATMENT OF ŒDEMA.

THE œdema of visceral maladies is the most amenable to active therapeutic treatment, says Prof. Huchard. For cardiac œdema the milk diet, drastic purgatives, digitalis, theobromine, and blood-letting are the arms to be used by the practitioner, according to the circumstances of the case. In cases of dilatation of the head, where the œdema increases in spite of digitalis and the milk *regime*, a reduction in the quantity of the liquid absorbed is frequently very beneficial—a pint and a half of milk mixed with the same quantity of water given daily for two or three days. Œdema in disease of the blood-vessels (arteries) is rare, but acute œdema of the lungs in affections of the aorta is frequently observed; it is possible, however, that the renal organs play a certain part in the production of this œdema. The treatment consists in abundant blood-letting and subcutaneous injections of caffeine or camphorated oil.

Œdema in venous affections is much more frequent, as in the case of varicose veins, and should be treated by the elastic bandage, massage, and the internal and prolonged administration of tincture of *hamamelis virginica* (5 drops twice daily).

Œdema caused by compression, cancerous embolic parasites (filiaris) of the lymphatic vessels receives the name of elephantiasis, and the treatment varies according as the malady is acute or chronic. In the acute form, the patients keep to bed, the parts are sprayed and acupuncture is done. In the chronic form, massage, the application of an elastic bandage and rest are all that can be done.

Œdema preceding ascites in cirrhosis of the liver appears frequently at a very early stage, and before any functional trouble due to the malady. When the lower limbs are sweated and the heart and kidneys are generally healthy, while the patient is thin and the conjunctiva has a sub-icteric tint, commencing cirrhosis may be suspected and an alimentary *regime* instituted—milk and farinaceous diet.

The œdema of renal affections is easily detected in acute nephritis as it is general and precocious; in the chronic form it is found in the eyelids and around the ankles. The treatment of renal œdema has received a considerable impulse through the studies of Achard and Vidal, who showed that salt was the dangerous element. The œdema is due to the retention of chlorides in the tissues, consequently the salt must be suppressed in the food. The patients can be allowed a quarter of a pound of meat, and the same quantity of bread (without salt), potatoes, eggs, rice, &c. The œdema disappears as readily as with the milk diet, the only advantage of which is that of containing a very small amount of salt per quart. As to the medical treatment it consists in giving theobromine. It is not always expedient to allow patients meat, as frequently under its influence the diuresis diminishes while the chlorides and the urea are but imperfectly eliminated. In any case where meat is allowed, ten grains of theobromine three times a day should be ordered.

Besides theobromine, other medicinal agents can claim a place in the treatment of chronic nephritis,

amongst which digitalin takes the first place when the malady is complicated with cardio-sclerosis with *bruit de galop* and tendency to dilatation.

The dose should be very small ($\frac{1}{10}$ milligramme) and continued for ten days every month. These weak doses tonify the myocardium without fatigue to the organ. All other drugs, caffeine, squills, spartein, strophanthus, &c., have much less value. The means of elimination of œdema are chiefly through the urinary tract and the intestines. If the heart is not too dilated, diuretic infusion may be given with the milk and theobromine, while drastic purgatives act well by depleting the possible œdema of the brain. General blood-letting may be also advised if the patient is strong enough to bear it.

Sudorifics render but doubtful service, but the method recommended by the Lyons school might be tried—rubbing the chest and back with an ointment of pilocarpine:—

Nitrate of pilocarpine, 2 grs;

Vaseline, 3 oz.

The parts are covered with cotton wool and gutta-percha sheet until profuse sweating takes place.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, February 5th, 1905.

At the Medical Society, a

MUSCLE ARTIST

was shown by Exc. von Bergmann, who by constant practice had learned to move individually as well as collectively or in different combination the muscles of his trunk, and especially those of the abdomen.

Hr. Guttman showed a case of

PRIMARY TUBERCULOSIS OF THE CONJUNCTIVA cured. The patient was a child, and the tuberculosis was contracted through the instillation, as was supposed, of drops. The diagnosis was rendered certain by the production of tuberculosis in rabbits and guinea-pigs through implantation of portions of diseased mucous membrane from the eye. The treatment consisted in cauterisation of the diseased surfaces with hot air, and success was attained in this way without causing any ectropion.

Hr. Gluck related a case of

CEREBRAL CYST.

In 1891 he had operated through the temporal bone for otitis and for three or four years afterwards the patient, a boy, had remained quite healthy. Then epileptiform convulsions commenced, which became more frequent. There was also headache, and at last some dulness of intellect, but no symptom of compression. The old cicatrix was opened, the bony flap thrown back, when he came upon a large cyst, which corresponded to the site of the old abscess. He emptied this and sutured up the cavity until only room was left for a small drain. Recovery. The absence of pressure symptoms was explained by the elasticity of the old cicatrix.

Exc. von Bergmann related a case of

SPURIOUS TRAUMATIC MENINGOCELE.

A man had suffered from slight injury to the skull eight years ago, and fifteen months ago a serious injury. The soft parts healed rapidly on both occasions, but after the last injury slight symptoms of disturbance remained. A year later a swelling suddenly appeared in the night over the right side of the head, and caused severe headache. The patient presented himself at the Klinik with a soft, fluctuating, tender, non-pulsating, and non-compressible tumour. By bending forward the pain was increased, but not the size of the tumour. It was a case of spurious traumatic meningocele, which had hitherto been observed in children only. Through an opening in the skull, a dilated emissorium Santorini, blood poured through out of the longitudinal sinus under the periosteum, so that the tumour filled with blood communicated with the sinus. Puncture showed the presence of fluid blood only. After some amelioration the blood re-collected. A bony wall

was felt at the circumference of the tumour, such as was felt in cephalhæmatoma. For radical cure closure of the opening in the bone was necessary, but this the patient declined.

Hr. E. Lessu spoke on the

FINSEN LIGHT TREATMENT OF LUPUS.

The question was approached from two points—(a) Was lupus absolutely curable by it? (b) Was a good cosmetic result obtained from its use? With regard to the first point, a definite answer was difficult as the treatment had only been employed during the past ten years; but it did seem as if recurrences were longer in taking place than formerly.

As regarded cosmetic effect, better results were obtained than by any other method, as only the diseased structures were affected by the treatment, and it in reality acted electively. So far as the lupus had destroyed healthy structures, these, of course, could not be replaced; but the treatment did not affect the healthy tissues as all other methods did. The X-rays appeared to act in the same way. Neither kind of ray had any specific action on the tissues. The action was merely that of a caustic, but the dose could be so accurately measured that the effect fell only on the diseased structures.

The Finsen treatment did not always lead to the desired result, and then other methods had to be tried in addition, such as cauterisation, hot air, X-rays, &c. X-ray treatment was a useful adjunct, but it was not suitable alone for the treatment of the disease.

Hr. Liebreich originally had the idea of raising the cells to higher vital activity by means of medicines. He used cantharides for this purpose long ago, and, in order to get more accurate dosage, in the form of cantharidate of soda. He gave it at first subcutaneously, but later on with equal success by the mouth. He had cured cases of lupus in this way that had remained seven and eight years without recurrence. He laid stress on his methods of examination, glass pressure, and phanerescopy. Cases of lupus shown as cured by the Finsen treatment yet showed nodules of the di ease under phanerescopy. There was no case of actual cure up to the present. It had even been observed that under the Finsen treatment new nodules were formed. Good cosmetic results were obtained; that was conceded, and it was a suitable aid towards attaining recovery. If the disease was to be definitely cured, however, it must be attacked from within, after that the Finsen or a surgical method of treatment might be brought into use.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, February 6th, 1905.

PERITONEAL RESISTANCE AGAINST INFECTION.

BORCHARD has been making further experiments with intra-peritoneal injections of nuclein serum from the horse and common salt with the object of increasing the resistance to poisons in the peritoneal cavity when operations are performed. If a nuclein salt be injected with a physiological solution of common salt eight hours before the operation, the result will be a perfect success. He calculates that the immunity lasts about four days.

Schmidt has carried this theory into the realm of practice by injecting five to ten cubic centimetres of sterilised equine serum in 250 to 500 cubic centimetres of a 0.9 per cent. solution of Na. Cl. into the peritoneum before operating on the abdomen. For this purpose he has constructed a special trocar whereby the wounding of the bowel can be avoided. His practice is to inject the fluid 17 to 19 hours before he operates.

LEUCONOSTOC HOMINIS.

At the Prague meeting Hlava gave a history of his experiments with leuconostoc, which, he said, were common to the buccal cavity and were stimulated into activity by different inflammatory processes such as coryza, angina, scarlatina, and morbilli, which increased their presence in the blood and produced toxic symptoms.

Whatever be their significance their presence is widely diffused, and though they may not be the true cause of the disease they are strongly connected with its advent. His experiments were confined to the genus of streptococci, and he demonstrated two cases of typhus exanthematicus to show how the convention of the leuconostoc hominis to the blood was accomplished. In the blood of these patients the germ was found coiled up and did not exceed the size of one-sixth of a red blood corpuscle; in another patient it was spermatozoidal in shape.

In the spleen blastomycetes, or spores representing that germ, were cultivated and produced the bacteria. Another form which this leuconostoc takes is the "tumeur perlée," at the base of the brain. The clinical symptom of this mysterious agent was that of bulbar paralysis. In a case of carcinoma of the bronchial walls having no typical infiltration of the subclavian gland, the same condition was found in the blood. In another case of peri-tracheal gumma, where tracheotomy was performed, a similar state of the blood was observed.

UTERINE MYOMA.

Rubeska gave a history of the different methods of operating on the uterus for myoma and polypi, or enucleation itself. He had performed the vaginal operation 50 times without a single death; laparotomy 71 times, with 4 deaths, or 5.6 per cent.; 2 cases he lost after supravaginal amputation from heart failure, and another two after total extirpation from a pulmonary embolus with subsequent sepsis. Rubeska recommends the vaginal method as the least dangerous and most easily performed. There are conditions when enucleation or amputation may be better performed by the abdominal method, but where practicable the vaginal is to be preferred. In young females, where the parametrium and collum of the uterus are to be retained entire, the vaginal operation is quite impracticable. Pitha said that he always preferred the abdominal operation as a more radical cure for the disease. The vaginal method was nothing more than a palliative operation and could not be accepted as a radical cure. Since the commencement of his abdominal operations his mortality had fallen from 24 per cent. to 11, which he considered a favourable figure.

MOLA HYDATIDOSA.

Ostréil related the history of a case of a racemose tumour which he had removed from a female, æt. 43, who had previously given birth to six children. She was admitted into hospital with great pain in the abdomen and a profuse discharge from the uterus. On palpation the uterus was found to be large and containing a fluctuating body. The hæmorrhage soon became profuse and associated with severe rigors, which induced him to commence dilatation of the neck by means of Bossi's instrument, which was completed with a "metreurynter." After twenty-four hours she was delivered of a racemose tumour weighing 1,600 grammes. The patient finally recovered without any untoward circumstances. He presumed that this course was the most favourable, for if the mole had been allowed to continue its interstitial destruction of the uterus, nothing short of total extirpation of the organ would have saved the patient.

MULTIPLE DIVERTICULA.

Honl demonstrated two cases of multiple diverticula of the small intestine. In the first case there were thirty-nine of these diverticulæ present, and in the second eighty-seven. The wall of each of these was composed of the usual intestinal coverings.

Trinity College, Dublin, Hilary Term, 1905.

Previous Medical Examination.—Anatomy and Institutes of Medicine: Archibald L. Robinson, George H. Stack, Eleanor E. Finegan and John W. Lane (equal), Wallace D. Mitchell.

Previous Dental Examination.—Materia Medica: Arthur K. M'Donald.

The Operating Theatres.

NORTH-WEST LONDON HOSPITAL.

ENLARGED SPLEEN IN FRONT OF RIGHT KIDNEY SIMULATING RENAL TUMOUR.—Mr. MAYO COLLIER operated on a woman, *æt.* 48, who had for the last six months complained of pain and discomfort in the right lumbar region. There was no history of having passed a renal calculus or renal colic. No jaundice or history of biliary colic. The patient had never been severely injured or subjected to a blow on the part. The lungs were apparently free from tubercle. There had never been blood or matter in the urine as far as the patient knew. She was the mother of several healthy children, and had not had difficult times during child-birth. The digestion was indifferent and the colour of the patient indicated that something was wrong with her nutrition. The condition of the abdomen when first seen precluded any possibility of making out the state of its contents, it was so extremely rigid, Mr. Mayo Collier subsequently examined the patient under an anæsthetic and could make out what appeared to be a large ovoid tumour in the right renal region, extending from below the liver to the iliac fossa. On bimanual examination, a feeling of fluctuation was very apparent. The left lumbar region was apparently quite free from anything abnormal, and the whole left half of the abdomen was found to contain no indication of anything unusual. Mr. Collier, with those around who examined the case whilst under the anæsthetic, came to the conclusion that this was probably a hydronephrosis or possibly a large tuberculous kidney, and determined on an early operation. Mr. Collier said if it turned out to be a large tuberculous kidney the incision as for lumbar nephrectomy would have to be combined with the abdominal incision, as the tumour would be too large to remove through the loin. If the case were a hydronephrosis or pyonephrosis, the lumbar incision for the present would serve. Mr. Collier made an incision midway between the last rib and the crest of the ileum, extending from the outer border of the erector spinæ downwards and outwards for about four and a half inches. On reaching the perinephritic fat the kidney could be felt apparently quite healthy, but in front of this was a hard, elastic mass with a free straight edge, movable, and not adherent to the kidney. In order to further elucidate the nature of the mass the peritoneum was incised and the tumour partly withdrawn from the wound. It was without doubt an enlarged spleen that extended from below the liver on the right side to the right iliac fossa. It did not extend to the left beyond the middle line. Its exact attachments above were difficult or impossible to make out from the number of adhesions to adjacent omentum and other organs. It having been decided not to proceed further, the abdomen was closed in the usual way and if the permission of the patient were obtained the mass could be removed subsequently by a median incision.

BECKENHAM COTTAGE HOSPITAL.

NEW METHOD OF DEALING WITH HÆMORRHAGE FROM THE STOMACH WHEN NO BLEEDING POINT CAN BE FOUND.—Mr. ARBUTHNOT LANE operated on a patient who had been admitted into the hospital under the care of Dr. Randall suffering from most profuse hæmorrhage from the stomach. He was practically in a dying condition, and it was obvious that the loss of

even a small additional quantity must of necessity prove fatal. Indeed, it seemed as if he would die on the table. The stomach was exposed and examined digitally throughout. It was then opened up along its anterior surface by a transverse incision and its mucous lining was gone over carefully. As in similar cases Mr. Lane had operated on previously, no bleeding point or abrasion could be discovered. He sewed up the incision in the wall and then proceeded to put ligatures around the gastric, pyloric, and right gastro-epiploic arteries, including a few veins which were in immediate contact with them. The wound in the abdominal wall was then closed. Mr. Lane said he had never previously attempted such an extensive ligaturing of vessels as in this case in which the stomach was left to depend for its blood supply on the left gastro-epiploic artery, nor had he heard of its having been adopted. The progress of the patient was most satisfactory, there being no recurrence of the hæmorrhage.

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The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, FEBRUARY 8, 1905.

THE SUNDAY AND KING EDWARD'S FUND —THE SPECIAL HOSPITALS AND AMALGAMATION.

THE more one inquires into the grants of the Metropolitan Sunday and the King Edward's Hospital Funds, the deeper grows the mystery. In previous articles of the present series it has been shown how certain hospitals receive regular awards, while others of apparently equal standing and possessing equal claims are sent empty away to labour under the unmerited slur of being ignored by the Funds in question. In this way two ancient and honourable institutions, the City Orthopædic and the Western Skin Hospitals, with a long and absolutely untarnished history, have been refused grants. In the case of the City Orthopædic, the reason given is that it refuses to amalgamate with the National Orthopædic. The City Orthopædic naturally objects to sell its freehold site and become swallowed up by the National, however much the Chairman of that institution may wish to swell the coffers of that charity, as he has already done by the purchase-money arising from the sale of the Royal Orthopædic

Hospital, a transaction that from a business point of view we regard as a scandal and a disaster. The Chairman of the National, (a) Mr. J. R. Cooper, we understand, is in a position to urge his views on the Sunday Fund, inasmuch as he occupies a position on the Council of that body. There is not the slightest evidence that he has ever used his influence with the Fund in order to secure any advantages accruing to the particular hospital of which he is chairman from the accumulation and absorption of other institutions. At the same time we think his dual capacity unfortunate in view of the serious and unanswered criticisms that have been laid for several years before the public by the Governors of the Royal, who opposed the sale of the site and were supported by the *Lancet* and by THE MEDICAL PRESS AND CIRCULAR. There are two members of the Council and of the Distribution Committee of the Sunday Fund, who act as its Honorary Secretaries, namely, Mr. Martin, of the St. Mark's Hospital for Fistula, and Mr. Gilliatt, of the Royal Chest Hospital. Again we think the dual position unfortunate. Both the hospitals named represent specialties that are, in the view of most medical men, superfluous and unnecessary. Both of them, however, receive liberal grants. We have not heard, moreover, of any pressure having been brought upon Mr. Gilliatt to amalgamate his chest hospital with one of the other special institutions of the kind in London. Why should the Funds fix on orthopædic hospitals to carry out their policy of amalgamation, regardless of the exchange of good freehold endowment for terminable bricks and mortar, and for the unjust dismissal of surgeons holding Scotch qualifications and other little items of injustice or disaster that may be entailed by amalgamation? There are many eye hospitals in London—why should they not amalgamate? So far from suggesting that, both the Funds we are criticising pour huge sums of money yearly into the coffers of the Royal City Ophthalmic Hospital (formerly Moorfields), which has been rendered bankrupt by the sale of an enormously valuable city site and its removal to another district. Why should the money of the public be bestowed upon this foolish virgin? The process is like pouring water into a sieve. If amalgamation were wanted anywhere, surely the Funds should begin with the City Ophthalmic. It is quite true, as pointed out by Sir Henry Burdett, that the King's Fund was not in existence when the Moorfields site was sold. The King's Fund, nevertheless, is helping the hospital to keep its head above water by grants that seem to us to be economically indefensible. From a consideration of the facts of the small hospitals that receive or do not receive grants from the Hospital Sunday and the King Edward's Funds, it is impossible to arrive at any general principles. Neither bankruptcy nor financial stability, neither a long and untarnished history nor years of un-

answered exposure in the columns of *Truth*, neither unceasing economy nor reckless extravagance, neither the desirability nor the superfluity of the particular kind of practice dealt with, none of these things appear to move the Funds one way or the other. The word has apparently gone round that orthopædic hospitals must amalgamate, that skin hospitals must be banned (except St. John's, which is no longer a hospital, but a limited company), that the Royal London Ophthalmic must be kept going at all costs, that certain specialties such as fistula and chest diseases deserve powerful support. It seems clear, moreover, although we have not enough facts to arrive at a firm conclusion, that one not unfavourable condition as affecting grants is to have friends at court; otherwise, on the Councils of the two Funds. In fact, it is to the non-representative nature of the Councils of the two Funds that much of the chaos to which it has been our duty to draw attention may be traced. We would respectfully urge that view both upon his Majesty the King and upon the Prince of Wales, who have hitherto shown a wise interest and wisdom in the guidance of the two great distributing charitable agencies with which they are so closely identified. The defects we have indicated are perhaps not in themselves of great magnitude, but they are none the less real to many persons whose interests, professional and otherwise, are involved. We suggest that the constitution of both the King Edward and the Hospital Sunday Funds would be greatly broadened and strengthened by the inclusion in future of representatives of the smaller hospitals, and by the publication of reasons for the withholding of grants from particular hospitals.

ARTERIO-SCLEROSIS.

No single condition in medicine is perhaps of greater moment than arterio-sclerosis, and yet so insidious is its onset and so indefinite are its early symptoms that it attracts far less attention to its study than its importance deserves. The subject formed the topic of some interesting papers at the Congress of Internal Medicine at Leipsic last year, and it was handled from different standpoints by several observers working in different fields of medicine. The old saying that a man is as old as his arteries was never truer than it is to-day. The conditions under which civilised man at present lives conduce not a little to early degenerations from fatigue and chronic intoxications. The wide-reaching significance of arterio-sclerosis was brought out by Bahrdt upon a study of the mortality-experience of life insurances, a study which led him to the conclusion that this condition, or its complications, caused the death of 22 per cent. of the insured. This heavy mortality-figure contrasts strikingly with a death-rate for the same offices of 7 per cent. from tuberculosis. Now, all life-assuring corporations are wide awake to the danger of tuberculosis as a cause of death, but arterio-

(a) By an inadvertence in our last issue the name of the chairman of the Amalgamated Orthopædic Hospital was given as Mr. Martin instead of Mr. Cooper.

sclerosis, probably because its mortality falls at a late period of existence and is generally returned under some other heading, is almost ignored. The diagnosis of early arterio-sclerosis is attended by the greatest difficulty, and much work is needed to elucidate the clinical symptoms that indicate its onset. Fortunately, instruments for measuring the calibre of the arteries and for estimating the height of the blood-pressure in them are becoming more trustworthy, though they have hardly yet attained a degree of exactitude that warrants their general application by those who are not fully accustomed to their complexities or vagaries, and it is only by studies on actual patients extending over many years, accompanied by observations by such instruments, that helpful information is to be obtained. The first symptoms apparent will probably be a distinct and constant rise in blood-pressure, a rise which may be due either to some thickening and want of elasticity in the vessel-walls, or to the operation of some general cause which, if continued long enough, would lead to such thickening. The *role* that mere increase in blood-pressure, apart from any other condition, plays in the etiology of arterio-sclerosis was shown by some experiments made by Erb, junior, and related at the same Congress. Erb injected daily into the vein of a rabbit's ear three drops of a 1-1,000 solution of adrenalin, and after six weeks of this treatment he found that the arteries showed diffused nodular thickening with calcification. Another animal, similarly treated for two months, showed even more striking vascular changes, namely, aneurysmal dilatation of the aorta and an apoplectic focus in the brain, together with general thickening of the arteries. Although no fatty degeneration was found in this case there was some calcification of the arteries and proliferation of the inner coat. Without holding these experiments to be conclusive, it may safely be said that they are highly suggestive of what may be termed a mechanical origin for arterio-sclerosis, in some cases at any rate, and thus it may be that a set of circumstances that throws a prolonged strain on the tissues and necessitates the maintainance of the blood-pressure at a high level for some time may, in the end, be found to have led to a permanent increase in the blood-pressure from the establishment of chronic arterio-sclerosis. This is all the more likely to be the case when the general nutrition is gravely affected by mal-nutrition or toxic influences, or when there is hereditary predisposition to early degenerative processes. The over-distension of the elastic and musculo-elastic coats of the arteries leads to a gradual replacement of the elastic layers by more lowly organised tissue, a change that is accompanied by compensatory hypertrophy of the other coats, and leads to diffuse or nodular thickening of the walls of the arteries. Atheroma, calcification and aneurysmal bulgings follow. Once established, arterio-sclerosis has effects of far-reaching

importance on every organ, due to chronic insufficiency of their blood supply, and these effects on the heart itself, through the calcification of the coronary arteries, on the brain and cord, on the kidney and other tissues, are well known. The treatment of arterio-sclerosis in its early stages was dealt with by Romberg and Gröbel, and they both agreed that though no drug known could alter anatomical lesions in the arteries, the iodides in small doses and the nitrates are useful in lowering general blood-pressure, and they also concurred as to the benefit derivable from carbonated baths and exercises. After removing the causes that had led to the initiation of the condition, such as alcohol, over-work and continued excitement, much benefit may be gained and life may be prolonged by judicious change of climate, rest, and much sleep. The bowels should receive special attention, and a good daily evacuation ensured, whilst a simple diet, rich in vegetables, is best. There is no doubt that arterio-sclerosis is a condition at once complex and little understood, and there is equally little doubt about its immense importance in view of modern conditions of urban existence. We should like to see more attention paid to its early recognition and treatment, for, once well established, nothing can prevent gradual decay and disintegration of the whole organism.

Notes on Current Topics.

New Navy Medical Regulations.

WE understand from semi-official sources that most important new regulations will shortly come into force with regard to the Navy Medical Department. The existing competitive system, if our information be correct, will be forthwith abandoned. In future, civilians with medical qualifications will be invited to take service for a short term of years. Pay is foreshadowed at the not illiberal rate of £1 per day, with, it is to be presumed, an extra grant for uniform. On retiring after a longer period than five years a gratuity of £500 will be awarded. By this means the Admiralty hope to secure a stage procession of surgeons who have not fallen into the almost inevitable rut of professional lethargy engendered by a prolonged experience of routine medical life at sea. On the other hand, they can hardly expect to command the services of highly skilled and experienced men at the rates of pay mentioned. Conversely, the five or six years' life at sea would be likely to injure the prospects of the young civilian surgeon to no small degree. At the outset of his career every day has an incalculable educational value to the embryo practitioner. A single voyage is often of value to the young qualified man, as it enables him to rest after the severe brain-fag entailed by passing his examinations, and at the same time enables him to see something of the world. A longer experience of the sea, however, is a snare and a delusion, so far as the formation of sound habits of professional study and observation are concerned.

Mr. Troutbeck's Mandate.

THE Westminster Coroner, Mr. Troutbeck, seems determined to "run amuck" among the medical practitioners of his district. On such an occasion as the death of an infant through overlaying he is not content to accept the evidence of the ordinary medical practitioner, but his thirst for scientific enlightenment compels him to call in Dr. Freyberger, the so-called County Council pathologist, to inform the Coroner and his jury with more precise, exact, and absolutely superfluous detail what was the state of the body of the suffocated child. Surely the point is the suffocation, which could be testified to by non-medical evidence and by the skilled testimony of the nearest medical man founded on external inspection of the body. Then Mr. Troutbeck, called upon to examine into the cause of death of a child who died under an operation for cleft palate, called in his faithful henchman, Dr. Freyberger, although what light the latter could throw on the case of more value than that obtainable from a house surgeon one cannot divine. The ratepayers have to pay an extra two-guinea fee—we understand that is the scale of pay—every time Dr. Freyberger appears on the scene. That is a matter, however, for the ratepayers to settle with Mr. Troutbeck. Truth to say, signs are not wanting that some of those concerned are getting a little restless under Mr. Troutbeck's autocratic and costly *regime*. A few weeks ago, Dr. Freyberger was called to give evidence in another overlaying case. One of the jury asked why that second opinion was necessary. Mr. Troutbeck is said to have made the feebly forcible reply, "Because I choose." The foreman of the jury, however, drove his bolt home by the following sentence addressed to the Coroner: "No doubt some cases you have to deal with require special skill, but this was a perfectly straightforward case, and in this, as in other cases, I think the doctors who devote their lives to the service of the people should be called." The attention of the Lord Chancellor should be drawn once again to the mediæval methods of the Coroner for Westminster. His high-handed action is becoming a public scandal.

The Increase of Insanity.

AN intelligent and well-instructed article on the increase of insanity appears in the *Westminster Review* from the pen of Mr. W. J. Corbet, for many years member of Parliament for Wicklow. He sets himself to combat the comfortable doctrine held by the Lunacy Commissioners of Great Britain and Ireland that there is only an apparent increase of lunacy in the Kingdom. We have ourselves criticised the doctrine at various times, and shown that while the apparent increase is greater than the real increase, it is only the policy of the traditional ostrich that forbids the recognition of the latter. Mr. Corbet points out that no talk of proportional increase of population or of more accurate enumeration of lunatics is

sufficient to account for the fact that during the past forty years the count of lunatics in the Kingdom has increased nearly threefold. If one takes the case of Ireland, one finds that the number of insane persons in 1862 was counted as 8,055, in 1903 it was 22,794. Yet during that time the population fell from five and three-quarter millions to less than four and a half. Nevertheless, the Lunacy Commissioners who are appointed by the nation for the special purpose of furnishing expert advice on matters relating to insanity deny that there is any problem to be solved. Mr. Corbet goes on to criticise the lack of progress in our dealings with insanity. "Measures for the prevention or alleviation of all manner of bodily diseases, from bubonic plague to phthisis and variola, constantly engage the attention of eminent scientists. The discovery of means to overcome or mitigate the fogs of London have quite recently been under discussion. Surely such matters are less important than the safeguarding of the sane from the contamination of the taint of insanity by inheritance." It is true that as yet we only touch the fringe of this great problem.

Recent Criticisms of Bart.'s.

EVER since the authorities controlling the ancient and noble charity of St. Bartholomew's decided to rebuild their hospital, they have been in hot water, and they must look back with regret to the piping times when they used to administer its vast resources secure from the breath of criticism. The re-building scheme, with its gigantic expenditure of money, has several times been the subject of articles in the pages of this journal, and we still adhere to our opinion that the wrong course was decided upon. Nor do we think that the attitude taken by the governing body has been free from blame; they have shown throughout their transactions a certain resentment at their policy being impugned by outsiders, and they are reaping the consequences in the shape of a pitifully feeble response to their appeal for funds. In Mr. Andrew Motion, chairman of the Cannon Brewery Company, has arisen a forcible critic from the Governors' own ranks, and he has taken them pretty severely to task on matters of internal administration. Mr. Motion promised, on behalf of the Cannon Brewery, a sum of £1,000 for every £100,000 that was raised toward the £500,000 required for the fund for re-building and carrying out the various alterations now on foot with regard to the charity, and he seems to have assumed that the company in due course would have become entitled to nominate a Governor for each £50 they subscribed. The Governors were glad enough of the cheques—of which only one has so far been paid, as the first £100,000 has not yet been subscribed—but they were rather taken aback by his expectation that the brewery company should nominate Governors, for, as they point out in their reply, this would give Mr. Motion substantial support in the management of affairs. It would seem

to the outsider a simple matter of tit-for-tat that a large subscriber should wish for proportionate representation in the administration of the money he subscribed, but to the Governors the idea seems a novel one, and therefore worthy of opposition. Mr. Motion referred to the large sum, £900 a year, that the Governors propose to pay their retiring clerk as a pension, and also to the fact that the son of this officer has been put into a position carrying with it a salary of £400 a year. The pension strikes one certainly as not erring on the side of niggardliness, and doubtless the Governors thought Mr. Cross' son capable of carrying out the work of his office; we are glad to see that they are prepared to defend their action in both instances. Many medical men who are giving a great deal of their time and energies to the hospital must, we should think, be rather sorry that they are not clerks; snug pensions of £900 must make their mouths water. At any rate, this sum formed the culminating point of the ambitions of Dr. Pangloss.

The Farnborough Libel Action.

THE slander and libel action which was tried last week in the King's Bench Division must have caused keen regret to all medical men. The action was brought by Mr. J. H. Peet, a practitioner at Farnborough, against Mr. T. G. Lithgow, of the same place, for certain defamatory statements the latter was said to have made with regard to Mr. Peet's conduct. Mr. Lithgow, in his capacity of Poor-law Medical Officer, was attending an old man who was very ill, and after performing a slight operation for his relief, he seems to have concluded that it was inadvisable to repeat it on account of the grave state of the general health. The Vicar of the parish, on a parochial visit, finding the man in much suffering, took the unusual course of consulting his own doctor, Mr. Peet, and sending him without Dr. Lithgow's knowledge to see the patient medically. Mr. Peet decided on his own account to perform the operation again, and a little later he did the same once more. On both occasions when the operation was performed the patient is said to have suffered much pain. Shortly afterwards the man died, and Mr. Lithgow was applied to for a certificate, and he then learned for the first time that Mr. Peet had been attending. Mr. Lithgow, after interviewing Mr. Peet and the Vicar, wrote a letter to the *Guardians*, couched in strong terms, animadverting on the conduct of Mr. Peet and the Vicar, and it was this letter that formed the subject of the action. The jury eventually decided that the libel had been substantiated, in spite of the privilege which has generally been held to attach to reports made by officers to their Boards, and Mr. Peet was awarded £50 damages. It is a painful matter at the best of times to see two members of a learned and charitable profession fighting out their differences in a public court, and one could wish that this matter had been settled before the

trial came on. It is needless to say what opinion medical men are likely to hold with regard to a *confre* who attends a patient without the knowledge and consent of the patient's own medical man, and almost equally needless to say that an ordinary court cannot be made to see the matter in the same light. That Mr. Lithgow acted unwisely in letting his indignation carry him to the point it did is obvious from the verdict, but it is not surprising that he should have been angry when the truth came to his ears. There are, we fear, few, if any, medical men who have not suffered at one time or another from the ill-directed zeal of ministers of religion.

Peculiar People.

IT is so long now since we came across the report of an inquest on the child of any of the "Peculiar People" that we had begun to think that the members of that sect—which perhaps of all others best justifies its title—had all availed themselves of the special dispensation granted by their elders allowing them to call in a doctor when their relatives were ill. However, we were mistaken, as we see that an inquest has just been held at West Ham on a child named Chignell, who died without benefit of doctors. As the cause of death was ascertained at the *post-mortem* to be tuberculous meningitis, the surgeon called at the inquest was unable to say positively that medical skill or attention could have relieved the patient, and as there was no other evidence of neglect, a verdict of "death from natural causes" was returned. The jury added their opinion that the parents should be cautioned, but the Coroner replied that he did not think it was much good doing so, as he had warned them so often before without result. The poor child had received the visits of elders on three occasions, and the usual anointing ceremony had been enacted, with much the same effect as these visits might be supposed to have. To argue or seek to convince these simple-minded folk of the folly of their ways would be to waste as much time as to argue with anti-vaccinationists on the protective value of vaccination. The relentless logic of facts stirs them as little as an earthquake in the Antipodes. Their attitude of mind reminds us forcibly of Huxley's old lady, to whom he had pointed out the error of Ussher's chronology, when viewed in the light of palæontological remains, and from whom he could only elicit the argument that fossils must by some Providential interposition have been put into the earth "to try our faith." The faith of the Peculiar People is as irreproachable as their integrity; it is only regrettable that it should conflict with the welfare of their offspring.

Erythema Infectiosum.

UNDER the above title a new symptom-complex was described by Stricker, of Giessen, and Escherich, of Graz, in 1899. Both of these observers claimed that it was a separate disease from

rötheln. The erythemata, as a class, are difficult to arrange in anything like scientific order, since the pathology of the different groups varies so widely. A great stir was made when Dukes described his "Fourth Disease" in 1900, but Ker, of Edinburgh, did not consider that the new affection answered the requirements of a malady liable to be confounded with rubella. The transient character of many erythematous eruptions often renders their diagnosis difficult or impossible, and when they are seen by artificial light they are notoriously deceptive. Dr. H. L. Keith Shaw, (a) of Albany, summarises the literature upon the subject and gives at the same time a good clinical account of the malady. It is a feebly contagious disease, occurring chiefly among children between the ages of four and twelve years. It is more prevalent in the spring and summer months. There appears to be an incubation-period of from six to fourteen days, at the end of which the characteristic maculo-papular, rose-red eruption shows itself upon the face. It is most pronounced upon the cheeks, the legs, and the outer surfaces of the arms. The rash fades upon pressure, and resembles both erysipelas and measles, but the subjective symptoms are extremely slight, there being no coryza nor desquamation. The glands are not enlarged, and there is no sore throat nor any elevation of temperature to speak of. The urine is normal throughout, and Koplik's spots are absent. The disease occurs in epidemics. Dr. Shaw suggests the term "erythema infectiosum morbilliforme," but he strongly repudiates the idea that it is an abortive form of measles. The absence of glandular enlargement and the intensification of the rash distinguish this complaint from rötheln.

Pulmonary Congestion and Sudden Death.

ATTENTION has been drawn from time to time to the occurrence of sudden death in patients whose bodies, *post-mortem*, show no definite lesion other than marked congestion of the lungs. Though some writers of authority, such as Brouardel, are sceptical in assigning congestion as the cause of death in such cases, yet as the number of these cases is multiplying it seems fair to regard it as the cause unless some more important lesion is discovered. Dr. Mince, who has recently published three cases of sudden death apparently due to congestion of the lungs (b) draws attention to a similar event as occurring in horses and other animals. In horses, fatal congestion, due in most cases to overdriving, is often accompanied by capillary hæmorrhage, and is then known as "pulmonary apoplexy." In other respects it presents marked resemblance to the appearance of the human lung after sudden death of this sort. It can hardly be said that the pathology of the condition is very clear, but it is to be hoped that all who have the opportunity of examining the body after sudden death of obscure origin will pay particular attention to the condition of the lungs.

Liability for a Nurse's Negligence.

OUR readers will remember the action for negligence taken against a London surgeon last year on account of the accident of leaving a foreign body in an operation wound. A somewhat similar case has just occurred in Canada, and as the points involved are not peculiar to Canadian law, it is worthy of mention. An operation for strangulated hernia was about to be performed by Dr. Bence, who brought with him a rubber water-bag for the operation-table. This he handed to the nurse, directing her to fill it "like an ordinary hot-water bottle." She, misinterpreting his instructions, filled it with boiling water, whereby the patient suffered painful but not severe burns. The nurse had not been employed by the operator, but by the ordinary attending physician of the patient. An action for damages by negligence followed. The judgment given decided that Dr. Bence was justified in expecting that a nurse would understand the filling of a hot-water pad, and that it was not his duty to supervise such details of the nurse's work. There had been, in consequence, no negligence on the part of the defendant. It is of interest that the case was decided by a judge sitting alone; if it had been tried by a jury it is not unlikely that the result would have been different.

Wounds in the Russian Army.

As all surgeons who served in South Africa are aware, the experience in that war has made a revolution in the treatment of bullet wounds. At the beginning of that war it was the custom to treat perforating wounds as if they were septic, and to operate in nearly every case, but a short experience showed that those cases did best which were left alone, and, on the whole, the mortality of bullet wounds proved unexpectedly low. From a letter of Professor von Manteuffel, who was attached to General Kuropatkin's army, it will be found that a similar state of things is observed among the wounded Russians in the Far East. The Japanese use a bullet of unusually small bore, which produces wounds of but little gravity. Perforating wounds of the abdomen, thorax, and cranium in most cases heal readily, unless where immediately fatal. Indeed, very often the bullet has but little "stopping power." It was not uncommon to apply a bit of plaster to a perforating wound before and behind, and allow the wounded man to continue on duty. Officers, too, continued to command, after suffering bullet wounds in the leg, abdomen, thorax or neck. The lack of "stopping power" of the Japanese bullets is to be attributed not only to their small size, but to their extreme hardness, which prevents "spreading." Professor von Manteuffel mentions an interesting point with regard to the shells in common use by the Japanese. They are filled with an explosive of such high power that when they explode they are reduced to fragments of mere powder, and are therefore comparatively harmless. In fact, the only

(a) *Amer. Journ. Med. Sci.*, January, 1905.

(b) *Boston Med. and Surg. Journ.*, December 22nd, 1904.

injuries from such explosions are rupture of the tympanic membrane and irritation of the mucous membrane of the nose.

Going the Round.

THE sincerest form of flattery is reputed to be imitation, but in all humility we would venture to suggest that an even more hearty compliment is transcription. This compliment is daily paid by one journal to another, and we are always duly grateful when each week we see the opinions and *obiter dicta* of the MEDICAL PRESS AND CIRCULAR transcribed and acknowledged by contemporaries in this country and America. To some journals, however, apt transcription's artful aid would seem to be the very breath of their nostrils, and we are amused at times to see the ingenuity that is exercised in the gentle art of dressing and pruning to fit the expressions of one journal for the consumption of the *clientele* of another. Amusement, too, may be gained by trying to pursue an article from one paper to another, and in tracking it to its source. We have been much puzzled of late to trace the origin of an article entitled "Some of Mr. Jonathan Hutchinson's Opinions." The bashful originator of this modest little production has evidently spent a profitable half hour with "Archives of Surgery," and extracted therefrom some of Mr. Hutchinson's ideas with regard to syphilis, leprosy, and skin diseases. Whether it be a tribute to the writer's gift of literary expression or to the renown of Mr. Hutchinson's name it might be invidious to inquire, but already this article has appeared in the *Pacific Medical Journal*, the *Journal of the American Medical Association*, the *Berlin klinische Wochenschrift*, and a medical publication in this country which finds its way unasked to the breakfast-table of most medical men in the Metropolis. This is as far as we have been able to trace it, but there may be yet other journals that have availed themselves of its services. It would be interesting to find the originator of this popular production. If he can write so well as to achieve quotation over half a hemisphere, he should have a brilliant literary career before him.

The Harmless, Necessary Bacillus.

A GOOD deal of entertainment was afforded to the officials and the public at the Southwark Police Court the other day by the hearing of an application by the Sanitary Inspector of Bermondsey for an order to destroy sixty tons of coffee, part of the cargo of a vessel which had been submerged in the Thames. The coffee was said to be "wet and moist and sodden," and one is somewhat surprised, therefore, that it should have formed part of the property of the Desiccated Grains Company; however, the latter fought the case to a successful issue, and as a sum of £50,000 was involved, it is not unnatural that they should have done their best. The prosecution called expert witnesses to show that

the coffee, after its sojourn in its watery grave, was permeated by *bacillus coli communis*, and that it was therefore unfit for use as human food. The defence admitted the presence of the bacillus, but contended that the organisms would all be killed in the process of roasting, a position that the sanitary authorities would not allow, as they held that even if the bacilli were all killed the products of their activity might still remain, and cause gastro-intestinal disturbance in the consumers of the coffee. Mr. Chapman, the magistrate, pursued the Solomon-like course of having a cup of coffee prepared from the impugned berries, and declared it looked and smelt like good coffee. He appears not to have ventured on tasting it. The defendants, however, produced a trump card in the shape of a medical man, who had had the courage of his opinions, and had drunk some of the coffee for two days beforehand without suffering any ill-effect. Mr. Chapman eventually decided that the evidence was not sufficient to enable him to order the destruction of the coffee—a decision which we think will be concurred in by most medical men reading the evidence. It is unfortunate that science is not able to speak unequivocally on these matters yet, but while bacteriology is in its infancy it is dangerous for its exponents to go into court and make dogmatic statements. The practical experiment of drinking the coffee would carry far more weight than any number of scientific theories.

The Pulse-Rate after Counting Aloud.

OF all the vital functions, that of the heart is most easily influenced by external conditions. The control exercised upon the circulation by the vaso-motor nerves is not always absolute, but is itself liable to be upset by the same causes. Variations in the rate of the heart-beat are continually being produced in accordance with the physiological need of an organ or tissue, but an increased frequency of the cardiac contractions is quite as often caused by psychic factors. Some years ago Professor Bernheim, of Nancy, observed that if the pulse-rate be taken while an individual is counting in a loud voice more quickly than the pulse, the speed of the latter is itself accelerated. In other words, the pulse tends to follow the counting. The difficulties of estimating the correct rate of the pulse while a person is counting loudly at a slightly higher speed are considerable, for there is an irresistible tendency on the part of the observer to count the spoken words rather than the pulse-rate. It is practically impossible for the subject himself to count both. In a recent communication upon the subject, Professor Bernheim (a) states that this difficulty can be overcome by the use of a Marey's sphygmograph, to which a recording cylinder is connected, and he has reported a series of thirteen cases in which the pulse-tracings were taken in this manner, the time in seconds being marked

(a) *Revue de Médecine*, December 10th, 1904.

in the usual way. The results varied according to the degree of arterial tension present. Thus it was found that in cases of normal tension an average acceleration of 9.5 beats per minute was observed in the pulse-rate after counting quickly in a loud voice, whereas, if the arterial tension was at all increased, this acceleration only amounted to an average of 6 per minute. A further series of cases is also recorded in which the counting was performed at a lower rate than that of the pulse, and it was noticed that a corresponding retardation of the pulse-rate was produced. In some cases, the mere suggestion of acceleration was sufficient to cause a quickening of the pulse-rate.

The "Nineteenth Century and After"—on Appendicitis.

ALTHOUGH that most excellent and classic review "The Nineteenth Century and After" may justly claim to be an authority on literature, art, and the ethics and the philosophy of life generally, it is none the less apt to go sadly astray when dealing with medical matters. Surely the Editor has enough ground of his own to cover without wandering into half-explored medical country in his eager quest for copy. Take the case of appendicitis, concerning which an article appeared in the last number of the "Nineteenth" from the pen of a writer better known in homœopathic than in orthodox medical practice. With an abrupt directness worthy of a Royal Duke of Russian origin, he traces all appendicitis to three causes, namely, chill, hurried eating, and aperient mineral waters. Of these three so-called causes, it is hard to say which is the most unlikely and absurd. "Chill" is the time-worn refuge of the incompetent physician, the thin and threadbare cloak of mediæval ignorance; hurried eating, well, if that were a cause of appendicitis, three-quarters of our citizens and nine-tenths of our schoolboys would be attacked offhand; while as to aperient waters—well, more of that anon. The whole trend of modern medical opinion points to bacterial action as the cause—the chief, well-nigh sole and invariable cause—of appendicitis. The bacterial mischief, in nine cases out of ten, follows constipation. Yet the sapient writer of the "Nineteenth" article is ready to throw overboard aperients—the sheet anchor of practical physic, past, present, and future. Clearly, he can have had little experience of the unspeakable value of natural mineral water in the treatment of constipation. Nature is a good physician, but a glassful of Hungarian water is often a better. In spite of all our admiration for the "Nineteenth Century" we would prefer trusting to orthodox medical sources for information as to how to prevent appendicitis. The article quoted reads like an echo of the Middle Ages. There are plenty of medical journals in London willing and able to deal competently with such a topic as aperient waters and appendicitis. There is really no need to trouble Fleet Street in the matter.

PERSONAL.

PROF. GILBERT BARLING, M.B., F.R.C.S., Professor of Surgery in the University of Birmingham, has been appointed Dean of the Faculty of Medicine in succession to Dr. Bertram Windle.

THE British Child-Study Association will meet at the Parkes Museum, Margaret Street, W., on Thursday, February 9th, at 8 p.m., when Dr. G. Shuttleworth will read a paper on some physiological problems in education. Sir Frederick Treves will preside at one of the meetings during the session.

PROF. PERRONCITO, now Director of the Veterinary School and Professor of Parasitology in the University of Turin, who discovered the presence of ankylostoma duodenale in the small intestine of the miner, has been permitted on the twenty-fifth anniversary of his discovery with an honorary degree from the University of Manchester.

THE Milroy Lectures before the Royal College of Physicians of London in 1906 will be delivered by Dr. W. H. Hamer, Medical Officer (General Purposes) to the London County Council.

SURGEON-LIEUT.-COL. EDGAR FLINN, V.D., who has recently resigned his commission in the Army Medical Reserve and Volunteer Medical Staff, has been granted the honorary rank of Surgeon-Colonel, with permission to retain his rank and uniform. He is one of the Inspectors on the Local Government Board (Ireland).

DR. HENRY O'NEILL, who has been nominated as High Sheriff for Belfast, is a keen advocate of city hygiene and has visited foreign capitals for the purpose of studying sanitary reform.

COLONEL W. A. MAY, C.B., Principal Medical Officer in Egypt, has been selected to succeed Surgeon-General W. Donovan, C.B., as Principal Medical Officer, Salisbury Plain District.

SURGEON-GENERAL W. J. FAWCETT, M.B., C.B., Army Medical Staff, is appointed Deputy Director-General, vice Surgeon-General A. Keogh, M.D., C.B., appointed Director-General, January 20th.

DR. KEENE, Surgeon to the British Steamer Ajax, of Liverpool, has been presented by the Czar with a gold cigarette case in recognition of his services to the Russian officers and men who were wounded at the naval battle off Chemulpo in February of last year, when the *Variag* was sunk. Dr. Keene is a graduate of Dublin University.

THE Inaugural Dinner of the Association of Medical Diplomates of Scotland will take place at the Trocadero, London, on February 14th. Tickets can be obtained from the Hon. Secretary, Dr. David Walsh, 18A, Hanover Street, London, W.

DR. GEORGE CHARLTON, of Montreal, has been appointed by the Government of the North-West Territories of Canada to establish a bacteriological and pathological laboratory at the capital of the Territories, Regina.

ON the nomination of the Council of the Royal College of Physicians, London, Dr. Thomas Buzzard, Dr. Watt Black, Dr. Clifford Allbutt, and Dr. Hale White were elected Councillors in the room of Dr. Gee, Sir Thomas Stevenson, Dr. Champneys, and Dr. Sharkey, who retired by rotation, and Dr. Percy Smith and Dr. de Havilland Hall were elected a fifth Councillor for one year and a member of the Finance Committee respectively in the place of Sir Isambard Owen, who has resigned these offices.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

SCOTLAND.

MILK SUPPLY.—An interesting table of the results of nearly 800 analyses of milk, representing the ordinary public supply in the eastern counties of Scotland, has just been published by Mr. G. D. Macdougall, F.I.C., City Analyst, Dundee. The average of the whole series gives 3.72 per cent. of fat and 8.81 per cent. of non-fatty solids. The highest figures were got in Earlsferry (Fife) with 4.20 fat and 9.09 solids; the lowest from Buckhaven, with 3.18 and 8.87, and Monkeithing, with 3.57 and 7.91 respectively. From data available, it is estimated that a difference of .1 per cent. in the amount of fat represents for each thousand inhabitants a money value of £8 per annum. Thus in Dundee the percentage of fat is approximately .45 per cent. below the average, representing a loss for the whole city of nearly £6,000 per annum.

SMALL-POX IN SCOTLAND.—The following was the number and distribution of cases of small-pox from January 16th to 31st, inclusive:—Haddington, 2; Lanark, 1; Flemingston, 1; West Marystone, 1; Airdrie, 1; Linlithgow, 1; Stirling, 1; Larbert, 4; Laurieston, 2; Stenhousemuir, 1; West Carron, 1; Falkirk, 5; Grangemonth, 1—22 in all. In the majority of these places no cases had been intimated in the month prior to the period of this report.

MORISON LECTURES.—The second course of these lectures on "Variation in its Relation to the Origin of Insanity and the Allied Neuroses," was delivered before the Royal College of Physicians by Dr. John Macpherson during the week ending February 4th. In the previous course various neuroses were dealt with, and now the lecturer dealt entirely with insanity. Insanity, as popularly understood, was not a simple disease but a complex of different affections, only related by the fact that they all had as a result or accompaniment a disturbance of normal mental processes. Pathology not being sufficiently advanced for the purpose, a clinical classification was the best to adopt, and etiological or symptomatological subdivisions could never be more than adjuncts to this. By far the most important of the main divisions into which insanity fell was the confusional or toxic group and the group of recurrent insanities. The type of the confusional group was the delirium of fever, the main symptoms being delirium, confusion, and stupor; the chief clinical forms were alcoholism, dementia præcox, and general paralysis. Their chief and only cause was poisoning by bacterial or metabolic toxins which destroyed the delicate cells of the brain cortex, and as in most cases this destruction was very rapid, the prospect of recovery was not good. About 40 per cent. of admissions to asylums belonged to the group. The presence of toxins in these cases might be inferred from the general course and pathological changes in these maladies; it was also recognisable clinically by the high blood pressure, pyrexia, and polymorphous leucocytosis. The lecturer showed by means of microscopic slides the intense destruction of the cortical cells in this form of insanity. The recurrent type of insanity presented a clinical picture entirely different from the confusional variety; there was no mental confusion, and the chance of recovery from any individual attack was good. There was, however, the unfortunate tendency to relapse, which was one of the points in which these resembled the neuroses. Neither mania, melancholia, nor paranoia ever resulted from an infection; to speak of delirium as mania because it was attended by excitement, or confusional insanity as melancholia because it was attended by depression, or to talk of typhoid causing melancholia, or alcoholism mania, was an error. Various slides were exhibited showing that the cortical cells remained intact after repeated attacks of recurrent insanity. Though insanity implied a susceptibility of the nervous system to yield to adverse influences, it was not wholly a disease of the brain, but the functions of many of the

body glands, as well as the immunity of the tissues in their resistance to invasion by toxins, had to be taken into account. It is an error to suppose that barbarous races have less insanity than civilised peoples; on the contrary, probably civilisation brings with it a tendency to decrease in insanity. The forms of insanity differ considerably according to the type of the race; thus Kraepelin's researches among the Javanese prove that among this people the prevalent type is an acute mania, of short duration, not unlike the Malayan lath. Similar forms occur among the Soudanese and the natives of Central Africa. A sharp distinction must be drawn between civilised communities which register their insane and those whose scientific appreciation of disease is so rudimentary that no provision of this kind is made. The amount of statistical insanity is therefore an index of their civilisation, and not of the relative amount of insanity. The statistics of insanity in Scotland fifty years ago were manifestly under-estimates of the amount of mental disease existing, and even now, with diminished prejudice and a much higher standard of diagnosis, it was impossible to estimate exactly the amount of mental unsoundness. Until such an estimate could be arrived at it was absurd to speak of insanity as increasing. The census returns for 1901 showed a much higher proportion of insane persons in the Northern and North-Western counties than in the Midland and Southern districts, and a similar difference exists between rural and urban districts. Grouping the populations of Argyll, Caithness, and Inverness on the one hand, and Glasgow, Edinburgh, and Dundee on the other, and correcting for age and sex distribution, it is found that in the former the proportion of pauper lunatics is 4.86 per thousand as against 3.06 in the cities named. Even in the counties themselves the same differences are found; parishes with industries, immigration, and an increasing population show a lower lunacy rate than those which are stagnating and have a dwindling population. The latter have an age distribution among their population peculiarly favourable to a high lunacy rate, the proportion of persons alive over fifty being higher than in the more prosperous parishes. It thus appears that a stagnant or dwindling population is at a disadvantage as regards statistical insanity—(1) because the age distribution of the population is abnormal; (2) because emigration removes chiefly strong, healthy adults, at an age at which they are not liable to insanity, and leaves behind the weak, diseased, and imbecile; (3) because, if insanity be present in such a depleted population, it tends to become inbred, there being no inducement for the return of young, healthy adults to introduce a new strain.

BELFAST.

PUBLIC HEALTH MATTERS.—The Belfast Corporation is showing some signs of interest in matters relating to public health, which it is earnestly to be hoped will continue. The medical officer of health has reported that a number of areas in the city are so bad as to be beyond the possibility of improvement, and the only thing to be done is to close the houses in these slums and destroy them. Of course, this fact has long been known to the public, but it is satisfactory to find it officially recognised. The matter has been referred to the surveyor and executive sanitary officer for further reports. Another thing which has long been known, but has only now been officially recognised, is that the expensive destructor erected some years ago is a failure, and, as one of the members of the Corporation said, might as well be pitched bodily into the Lagan. The reticence of the Public Health officials regarding the destructor has been mentioned in this column on several occasions, when the annual report of the Medical Officer of Health was under criticism. It appears that the affair has now stopped work, owing to some dispute between the Corporation and the contractor. During the five weeks ending last week, 210 cases of zymotic disease had been notified, including 60 scarlatina, 39 erysipelas, 36 typhoid, 28 simple continued fever, and 24 small-pox. One of these last cases proved fatal, the patient being a man who had never been vaccinated.

A scheme of prizes for house cleanliness has been submitted to the Public Health Committee, and has been approved by them. The competition is open to all occupiers of houses in Belfast at a rent of less than 4s. per week, and three prizes are offered entitling the winners to 52, 26, and 13 weeks' free occupation of their houses. The prizes will be awarded to those who keep their houses in the most sanitary condition from March to December of this year. The idea seems an excellent one, and it is to be hoped that the number of prizes will be largely increased.

Correspondence.

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

CAUSES OF APPENDICITIS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The general reader would be glad to have some light thrown upon these frequent cases of appendicitis occurring now and then in all classes of society. We have not been furnished yet with a sketch of the physiological functions of the appendix vermiformis in the bodily economy, why it is an isolated tube, why it is attached always to the same place, and why its extremity is always loose. It has been surmised that appendicitis is connected with some errors of diet, but some hesitation may be felt to accept this in general as it arises in various classes of society under different regimens of food.

It is more probable that its cause lies in a similar category as those of hernia, and is more connected with perverted or misdirected muscular action of the body.

This idea may suggest attention to the abuse of cycling or motoring as a probable contributory cause, as the new disease seems contemporaneous with this modern form of locomotion. As the rolling and pitching of a ship in rough weather will bring on sea sickness by disturbing the natural pose of the bowels, so may the exercise of rapid cycling misdirect the localisation of the bowels, and cause motion to parts usually in a state of repose.

It would be of some interest, then, to direct inquiry to patients thus affected if they were in the habit of cycling or motoring frequently, and if the motion gave rise to any pain in the abdomen or disturbance of the functions of the bowels. I dare say a predisposition to hernia may be incompatible with horse exercise in the male, but the same cannot be alleged in the case of the female, as the seat on the saddle is flat, and puts no strain on the inguinal structures.

As appendicitis is a modern affection, so it may not be alleged that it is due to horse riding by either sex, a form of exercise of very ancient usage.

I am, Sir, yours truly,

W. V. BLACK, F.R.C.S.E.

Southport, February, 1905.

REVIVALISM AND MENTAL DISEASE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your issue of January 18th, you call attention to what I may be allowed to style an epidemic of religious excitement, and as there appears to be a desire on the part of well-meaning and disposed teachers of religion to encourage this ecstatic condition of mind, it becomes a question how far it may be considered conducive to the public health.

There can be no doubt, I submit, that a *mens sana in corpore sano* affords one of the best securities for social order and morality, and it is questionable whether violent efforts to arouse the public mind to steer in the path of rectitude, however well intended, will prove in the long run conducive to a robust state of health.

Now, Sir, although unanimity of opinion exists among the officials presiding over our asylums as to alcoholic excitement being a powerful factor as a cause of insanity, notwithstanding their statistics may be formulated on different methods of calculation, and

hence at variance, it is by no means obvious, at least to my way of thinking, after all said, taking into consideration the number of cases in our asylums suffering from religious delusions, and also the circumstance that so few drift in the path of religious excitement compared to the many who suffer from alcoholism, I say it is questionable whether religious fervour, if allowed to run to its height, would not be as powerful a factor in producing insanity as drink. However this may be, it is certain and obvious to any common observer, if he only review the development of the human mind throughout all ages and the consequences of religious excitement and fanaticism, culminating in religious wars and other excesses, that it is no groundless fear to suggest the policy of "moderation in all things."

I am, Sir, yours truly,

CLEMENT H. SERS,

Brighton, February 4th, 1905.

REVIVALLENZA.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Does it not rather look as if we are liable to epidemics of mental disorder, like those that disturb our health? It matters not what the religion of a country may be; all are liable to these disturbances.

The interesting question, of course, is, What is the cause of them? and as there is no doubt that they are evidence of a morbid mental state of a people, it might be well, as we have to deal with questions of insanity, if we gave some little attention to this recent malady—Revivalenza.

I am, Sir, your truly,

R. L.

MR. STEPHEN COLERIDGE AND THE HOSPITALS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Mr. Sydney Holland expresses a doubt that he ever taunted me with not being a subscriber to the London Hospital.

On January 20th, 1903, a letter of his appeared in the *Morning Post*, in which he said it was impertinent of me to want to see the accounts of the Medical College, and assigned as a reason that I was "not only not a subscriber to the hospital, &c., &c."

He asserts also that I have "preached to everyone: 'Don't subscribe to the London, don't subscribe to Guy's.'"

I should like to see any publication of mine justifying that assertion.

I am, Sir, yours truly,

STEPHEN COLERIDGE.

London, January 11th, 1905.

NATIONAL PHYSIQUE AND NATIONAL DEFENCE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—May I ask you to be good enough to allow me to draw the attention of your readers to an important address, on the "Physical Advantages of Universal Naval and Military Training," which was given by Lieut.-Colonel O. T. Duke, until lately Hon. Secretary of the Lads' Drill Association, at the Caxton Hall, Westminster, at 5.30 p.m. on Tuesday, February 7th, Sir William Church being in the Chair?

In urging the adoption of a moderate form of universal naval or military training for national defence, the National Service League looks to wider issues than those involved in questions of defence alone, important as they are. We believe that a truly national system of training, which would reach the boy at school and the youth as he attains manhood, could not fail to have a profound effect on the physical condition of the people, not only by the direct improvement involved, but by drawing the attention of the nation to the many causes which, in a highly industrial country like ours, are at work to undermine the health of the community.

The intimate relationship between the two great questions of national defence and national physique leads me to express the hope that many of your readers,

to whom one at least of these questions appeals in a special manner, will peruse Colonel Duke's lecture,

I remain, Sir, yours truly,

GEORGE F. SHEE,

Secretary, The National Service League,

Dacre House, Victoria Street, S.W.,

January 27th, 1905.

CENTRAL MIDWIVES BOARD.

Most of our readers will be interested in the scheme of examinations approved by the Privy Council, January 17th, 1905, and laid before the Board at their meeting on January 26th.

EXAMINATIONS.

(1) Every examination shall be partly oral and practical, and partly written, and shall be conducted by not fewer than two examiners. (2) The first examination shall be held in June, 1905. (3) Thereafter the examination shall be held three times a year, or oftener if necessary, in London and the Provinces, simultaneously, on the same papers. "The Board reserves to itself the right to appoint one or more qualified medical practitioners as visitors of the examinations, both London and provincial." (4) The first provincial centres shall be (a) Bristol, (b) Manchester, (c) Newcastle-on-Tyne.

EXAMINERS.

(1) A list of examiners, both for London and the provinces, shall be prepared by the Central Midwives Board from those who are willing to serve and act, when required, by the Board. This list shall be subject to annual revision by the Board. Before such a list is formed applications for the post of Examiner shall be invited by advertisement. (2) All examiners shall be men or women who are duly qualified medical practitioners. The examiners may, when they see fit, with the consent of the Board, employ for certain parts of the examinations properly qualified women who are not medical practitioners; their remuneration being provided out of the sums payable to the examiners for the conduct of examinations. (3) No examiner shall examine his own pupils. (4) A paper of directions to examiners shall be drawn up and issued to each examiner on his appointment. (5) The remuneration of an examiner shall be at the rate of seven shillings for each candidate examined, with a minimum fee of two guineas for each examination. (6) The examiners, both London and provincial, shall be invited to meet at the offices of the Central Midwives Board as often as may be necessary.

LONDON EXAMINERS.

(1) The arrangements for the London examinations shall be made by the Secretary of the Central Midwives Board, with such extra assistance as may be necessary. (2) The duties of the London examiners shall be: (a) To consider examination questions suggested by provincial examiners. (b) To set all the papers of examination questions both for London and the provinces. Two of the examiners, with the assistance of one of the medical members of the Central Midwives Board, to be appointed for the purpose, shall undertake this duty in rotation. The remuneration of the examiners in respect of this duty shall be two guineas each. (c) To conduct the examination, written and oral, of all candidates presenting themselves for examination in London. (d) To report to the Central Midwives Board the result of each examination held in London as soon after the examination as possible.

PROVINCIAL EXAMINERS.

(1) The examiners appointed by the Central Midwives Board to conduct the Board's examinations in a provincial centre shall assist the secretary of the Board in making the necessary arrangements for the examinations. (2) The duties of the examiners in each provincial centre shall be:—(a) To conduct the examination, written or oral, of all candidates presenting themselves for examination at the centre. (b) To report to the Central Midwives Board the result of each examination held at that centre, as soon after the examination as possible.

DIRECTIONS TO EXAMINERS.

(1) The paper shall consist of not fewer than six questions, and the time allowed for answering shall be three hours. (2) Notes should be taken, either by the examiner himself or by a colleague, of the subjects upon which the candidate is questioned in the oral examination. (3) Fifteen minutes should be considered an average period for the oral examination of each candidate. (4) Examiners should avoid questioning candidates as to where and by whom they were trained, so as to avoid any suspicion of bias.

INTERNATIONAL MEDICAL CONGRESS, LISBON, 1906.

A MEETING of the National Committee for Great Britain and Ireland of the Fifteenth International Congress, to be held at Lisbon April 19th to 26th, 1906, was held at the rooms of the Medical Society of London on February 3rd, 1905. There were present, among others, Dr. Pavy, F.R.S., President of the National Committee, Sir William S. Church, Bart., K.C.B., Sir Dyce Duckworth, M.D., Dr. Ferrier, F.R.S., and others; and the Hon. Secretaries, Dr. Clive Rivière and Mr. D'Arcy Power. It was announced that the following gentlemen had undertaken to act as "Rapporteurs" at the forthcoming Congress, as it was the wish of the Lisbon Committee to make the "Rapports" a special feature of the meeting. Dr. Stanley B. Atkinson, Hon. Sec. of the Medico-Legal Society and barrister at law, "Spontaneous and Criminal Abortion from its Medico-legal Aspect." Dr. Chalmers, Medical Officer of Health for the City of Glasgow, "The Administrative Control and the Technique of Public Disinfection." Mr. Treacher Collins, "Ocular Tuberculosis." Prof. Ferrier, "The Nature and Pathological Physiology of Tabes." Mr. Goadby, Lecturer on Bacteriology at the Dental Hospital, "The Treatment of Pyorrhœa Alveolaris." Dr. Gulland, "The Classification, Origin, and Probable Role of Leucocytes, Mastzellen and Plasma Cells." Sir Patrick Manson will open a discussion on Tropical Medicine. Dr. Mott, "Cerebral Lesions in Psychoses of Toxic Origin." Mr. D'Arcy Power, "Recent Advances in the Surgery of the Arteries and Veins." Dr. Still, "The Spastic Affections of Childhood, their Classification and Pathogeny." Dr. Sutherland, Deputy Commissioner in Lunacy for Scotland, "The Prophylaxis and Treatment of Habitual Criminals." Mr. C. E. West, Chief Assistant in the Aural Department at St. Bartholomew's Hospital, "Study of the Elephantine Action of Foreign Bodies in the Ear and of Post-Nasal Growths." The subjects for the "Rapports" were selected in every case by the Executive Committee at Lisbon.

A letter was read from Messrs. Cook, containing a proposition to charter a first-class passenger ship to convey visitors to and from Lisbon, calling at Oporto, Vigo, and Corunna, and acting as a floating hotel during the Congress week. The suggestion was approved by the Committee, but Messrs. Cook were desired to ascertain the exact position of the anchorage in the Tagus, that inquiries might be made locally as to its suitability, both from the point of view of the hygienic surroundings and of distance from the seat of the meetings of the Congress. Letters were read from Dr. Ogilvy Will and from Dr. J. F. Sutherland giving the results of certain inquiries which they had made in regard to the housing of those who did not wish to go by sea and remain on the boat. It appeared from these inquiries that rooms could now be obtained at a moderate price at Cintra, about 40 minutes by train from Lisbon. The hotel is well spoken of and the proprietor says that, at present, he has 16 bedrooms, most of which can be used by two persons. It appears imperative, therefore, that those who intend to go to the Congress and do not wish to depend on the efforts of the local Committee to obtain lodgings should at once take the opportunity of reserving rooms. Delay is likely to lead to the same disastrous consequences as at Madrid.

Obituary.

JOHN MARRIOTT, M.B.LOND.

WE regret to announce the death of Dr. John Marriott, at the age of forty-four, while on a visit to Harrogate. Deceased was to have been married last Wednesday to Miss Bertha Wilson, of Harehills, Leeds, but at midnight before the wedding day he was discovered lying unconscious underneath his bed-room window, and died soon afterwards. He had taken tickets from Leeds to London for himself and his prospective bride. Dr. Marriott was settled in practice at Northampton, and was at one time House Surgeon at Charing Cross Hospital. He graduated M.B. of London University in 1885 and M.R.C.S.E. in 1881.

GEOFFREY HETT, M.D.EDIN., M.R.C.S.ENG.

WE regret to announce the death of Dr. Geoffrey Hett, of 41, Westbourne Park Road, on January 25th, aged 61. Deceased was educated at Merchant Taylors School, then at King's College and the University of Edinburgh. After serving as house surgeon successively to the Lincoln dispensary and hospital, he settled in London and spent most of his life as a Bayswater practitioner. At one time he was honorary secretary of the Royal Medical Benevolent College. He was a busy worker in literature as well as in medical practice, and made numerous contributions to the *Saturday Review* and other journals. He was for very many years one of the honorary medical staff of the Westbourne Provident Dispensary. His death from heart failure will be felt by a large circle of friends.

New Appliances.

THE GLASEPTIC NEBULISER.

MESSRS. PARKE, DAVIS AND Co. have sent us a sample of a very workmanlike nebuliser suited for atomising fluids of any density. From a practical test we are enabled to say that it admirably fulfils the essential requirements of such an apparatus, which have been kept steadily in view by the makers. The points in question are that the working parts should be made entirely of glass, and thus be free from all possibility of oxidation or corrosion; that the instrument should be easily cleansed, and thus rendered perfectly aseptic; that it should be effective for nebulising or atomising liquids of practically any density or viscosity; that it should be capable of being used with a few drops of liquid; and, lastly, that it could be corded up to prevent evaporation or oxidation, or spilling of the liquid in the event of the apparatus being carried in the pocket. This little appliance is certainly one of the most perfect things of the kind that have hitherto come under our notice.

Medical News.

Influenza in Brussels.

THE special correspondent of the *Globe* reports that for the first time in the memory of Brussels opera-goers, the Monnaie was last night obliged to close its doors unexpectedly, owing to the illness of a number of its artistes. For some weeks the management of the opera has been fighting against the disabilities caused by the spread of influenza among the operatic staff, but, last night, the inevitable had to be conceded to on the principal tenor being struck down.

Centenary of the Royal Medical and Chirurgical Society.

It is announced that the centenary of the Royal Medical and Chirurgical Society will take place on May 22nd, 23rd, and 24th. There will be a reception by the President, together with an exhibition relating to medical matters of one hundred years ago, a festival dinner, and a *conversazione* at the Royal College of

Surgeons. It is expected that the exhibition will be of special interest, and any members of the profession or others who are able to lend anything of medical interest belonging to that period will be forwarding the success of the celebration. The exhibits will be strictly limited to what was in actual medical and surgical use in 1805; even medicine bottles, pharmaceutical apparatus, and old prescriptions of or about that date would find a place. The following distinguished scientific men have been nominated for the Honorary Fellowship of the Society:—Professor Nothnagel, of Vienna; Professor Welch, of Baltimore, Professor Marchiafava, of Rome; Dr. Ramon y Cajal, of Madrid; Professor Pavloff, of St. Petersburg; Professor Kitasato, of Tokio; Professor Bohr, of Copenhagen; Lord Rayleigh, Sir Samuel Wilks, Sir William Ramsay, Sir William Gairdner, Lord Lister, Dr. Gaskell, and Dr. Robert Barnes.

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 27th ult. at 429, Strand, London, W.C. There were present Dr. de Havilland Hall, in the chair; Dr. G. A. Heron, Dr. J. Brindley James, Dr. M. Greenwood, Dr. J. W. Hirst, Dr. St. Clair B. Shadwell, Dr. Fred. S. Palmer, Dr. W. Knowsley Sibley, and Dr. J. B. Ball. The accounts presented showed that a considerable number of sickness claims arising from influenza had been received during the last few weeks, but they had for the most part been of short duration, and the list is now very little longer than is expected at this season of the year. The time of the committee was principally occupied in examining the special reports which in every January are furnished on what are called chronic cases. There are now nearly twenty-nine of these cases on the books and the reports received show that in all of them the members will probably draw their allowances, usually one hundred guineas a year, as long as their membership lasts. This practically permanent provision for those who can no longer work is considered one of the most important features of the Society's operations. Prospectuses and all other particulars, on application to Mr. F. Addiscott, Sec., Medical Sickness and Accident Society, 33, Chancery Lane, London, W.C.

Cure of Consumption.

SOME years ago the Poor-law authorities in Liverpool and district combined in the erection of a consumption sanatorium at Hesswall on the River Dee. At a meeting of the Liverpool Select Vestry on the 31st ult., a report was presented showing that the cost of maintaining the hospital was high and the results disappointing. Liverpool had ten beds in the hospital, and if they were occupied all the year round the cost would be £3 a week per patient, or a total of £1,560. In the two years' work of the hospital, of thirty-eight Liverpool patients discharged in three cases the disease was arrested, nine had died, sixteen had been re-admitted, two were in failing health outside, and eight had not reported. A member said that the Hesswall institution would soon be closed, and possibly that the building could be used for epileptics. Consideration of the recommendation was deferred.

THE Royal Maternity Charity of London, under the patronage of H.M. the Queen, has published its medical report for 1904. The total number of cases treated was 3,290, and there were 1,774 boys born as against 1,571 girls. The mortality was remarkably low, being only 1'51 per 1,000 in the case of the women, and 6'40 in the case of the children. The causes of death in the cases of the mothers were placenta prævia, pulmonary embolism, infective enteritis and collapse, enteric fever, exhaustion, following prolonged labour, in a poorly nourished patient.

Notices to Correspondents, Short Letters, &c.

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

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 re-forwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

DIMINISHING BIRTH-RATE (Birmingham).—The correct name of the Society is The American Mother's Birth Insurance, Massachusetts, constituted for the purpose of paying a sick or disability benefit upon the birth of a living child.—Its Officers serve without compensation and it enables parents to provide in advance for a coming family.

SCOTCH DIPLOMATE.—We think you are wise in joining the A.M.D.S. Such medical societies constitute the chief element of strength in the organisation of the profession and are useful for the cultivation of fellowship, the exchange of professional experiences and acquiring much useful knowledge.

CIVITAS (K.S.).—We agree that the appointment of a Minister of Public Health is very desirable. In Belgium, Canada, and the U.S.A. the control of Public Health is vested in the Depts. of Agriculture and Navy, in France and Austria, in that of the Interior; in Germany in Police and Education, Sweden alone vesting it in a medical Council.

M.S.—The superheated air baths, followed by skilled massage ought to do good in the case you mention of muscular rheumatism in chronic Bright's Disease.

J. K. ROBERTSON.—Quite so, too strong a solution of perchloride of mercury may defeat its own object and set up an intense conjunctivitis neovascularium.

POST-MORTEM (Sunderland).—In the case of special liberties the appointment of Coroner is often made by the crown. In large towns the salary varies from £800 to £1,500 per annum. In all the cases it is usually small being calculated on the number of inquests held annually.

X. Y. Z.—Shingles may occur in chronic patients after arsenic, it is not necessarily always due to the drug, but may depend upon some trophic influence of the affected nervous system.

CLEAN SHAVEN MEN.

An ingenious advertisement has been issued by the proprietors of Wrigth's Coal Tar Soap in the shape of any person sending the nearest estimate of the number of clean shaven men there are in 10,000. It will be interesting to learn how the standard test number is arrived at, for it must be exceedingly difficult to get precise statistics of the kind. A fair proportion of medical men are clean shaven.

"COUNTRY SURGEON" writes about the prescribing of opium in appendicitis and other acute abdominal conditions. He rightly insists that the practice is a survival of the dark period when little was known about the maladies of the kind, and the only thing left to be done was to provide an euthanasia for the patient. Nowadays the skilled medical attendant approaches such cases, so to say, with a scalpel in his hand.

SHIP SURGEON.—Many lines make the marine insurance compulsory. We think the practice unfair in the case of a ship surgeon, who as a rule simply joins for a few voyages. It is advisable for him to see that the insurance covers *partial* as well as *total* loss. Otherwise if he escapes shipwreck with even a pocket case, he may forfeit all claim for compensation.—*Verbum Sap.*

An ordinary meeting of the Central Midwives Board, followed by a special meeting, will be held on Thursday, Feb. 9th. The Press are invited to attend at 4 p.m.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, FEBRUARY 8th.

SOUTH-WEST LONDON MEDICAL SOCIETY (Bollingbroke Hospital, Wandsworth Common). 8.45 p.m. Paper.—Mr. G. H. Makins: Some Remarks on the Indications for Gastro-jejunostomy and its Results.

DERMATOLOGICAL SOCIETY OF LONDON (11 Chandos Street, Cavendish Square, W.).—5.15 p.m.—Demonstration of Cases of Interest.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. H. L. Barnard: Clinique. (Surgical.) 5.15 p.m. Dr. G. H. Savage: The Relationship between Suicide and Insanity.

THURSDAY, FEBRUARY 9th.

BRITISH GYNÆCOLOGICAL SOCIETY (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Dr. Macnaughton-Jones. The President (Dr. W. Alexander): Inaugural Address.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Titchborne Street, Edgware Road, W.). 8.30 p.m. Dr. G. A. Sutherland: Clinical Observations on Lobar Pneumonia in Children.—Mr. E. L. Evans: Anterior Metatarsalgia with Notes on Seven Cases.

CHILDHOOD SOCIETY AND THE BRITISH CHILD-STUDY ASSOCIATION (Parkes Museum, Margaret Street, W.).—8 p.m. Lecture.—Dr. G. E. Shuttleworth: Some Physiological Problems in Education. (Arranged by the British Child-Study Association.)

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—8.30 p.m. Papers.—Mr. E. Stevenson: Notes on a Case of Large Orbital Exostosis removed by Operation (with specimen).—Mr. C. Wray: The Treatment of Tobacco Amblyopia.—Mr. E. T. Collins and Mr. R. Batten: Membranous Fibroma of the Eyeball and its Appendages.—Mr. A. Ogilvie: Exostosis of Orbit.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchingson: Clinique. (Surgical.) 5.15 p.m. Mr. A. H. Tubby: Orthopedic Surgery.

MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST (7 Fitzroy Square, W.).—5 p.m. Lecture: Mr. H. Barwell: Laryngeal Paralysis and their Value for Diagnosis. (Post Graduate Course.)

FRIDAY, FEBRUARY 10th.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8.30 p.m. Papers.—Dr. W. Ewart: A Case of "Soft Valve" Mitral Stenosis in which no murmur was heard.—Mr. E. P. Paton: A Case of Accessory Thyroid laterally placed in the Floor of the Mouth.—Mr. H. B. Robinson: Extraperitoneal Uterero-lithotomy in a Child aged three years.—Mr. D. Drew: Calculous Anuria in a Child.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Dr. W. J. Horne: Clinique. (Throat.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Mr. R. P. Brooks: Myopia.

MONDAY, FEBRUARY 13th.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Dr. A. G. Whiting: Electro-Diagnosis.

Vacancies.

Somerset and Bath Lunatic Asylum, Wells, Somerset.—Medical Superintendent. Salary £800 per annum, with furnished house and allowances. Applications to John Coates, Clerk to the Visiting Committee.

Craig-Leith Poorhouse and Hospital, Edinburgh.—Medical Officer. Salary £100 per annum, with board and apartments. Applications to And. Ferrier, Clerk, Parish Council Chambers, Castle Terrace, Edinburgh.

Brompton Hospital for Consumption and Diseases of the Chest.—Assistant Resident Medical Officer. Salary £100 per annum, with board and residence. 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.

Egyptian Government—Ministry of Public Instruction.—Professor of Pathology and Bacteriology at the School of Medicine, Cairo. Salary £800 per annum. Applications to the Director, Government School of Medicine, Cairo, Egypt.

Royal London Ophthalmic Hospital (Moorfields Eye Hospital), City Road, E.C.—Curator and Librarian. Salary £120 a year. Applications to the Secretary.

St. Helens.—Surgeon to the Works Sick Club. Salary £200 per annum, with furnished residence, light, heating, and attendance. Applications to P. B., Box 38, Post Office, St. Helens.

Beckett Hospital, Barnsley, Yorkshire.—Resident House Surgeon. Salary £100 per annum, with board, lodging and washing. Applications to Ralph F. Pawsey, Hon. Secretary, Barnsley.

Grove Hall Asylum, Bow, London, E.—Assistant Medical Officer (Male). Salary £150 per annum, with board, furnished apartments. Applications at the above address.

County Council of Middlesex.—Napsbury Asylum, near St. Albans, Herts.—First Assistant Medical Officer. Salary £200 per annum, with board and lodgings. Applications to Walter Geo. Austin, Clerk of the Committee, Guildhall, Westminster, S.W.

County Council of Middlesex.—Napsbury Asylum, near St. Albans, Herts.—Third Assistant Medical Officer. Salary £100 per annum, with board and lodgings. Applications to Walter Geo. Austin, Clerk of the Committee, Guildhall, Westminster, S.W.

Cancer Hospital (Free), Fulham Road, London, S.W.—Assistant House Surgeon. Salary £70 per annum, with board and residence. Applications to the Secretary. (See Advt.)

Richmond District Asylum.—Two Clinical Assistants. Salary £80 per annum, with furnished apartments, &c. Immediate Application to C. Norman, Medical Superintendent. (See Advt.)

Patrick Stead Hospital, Halesworth.—Surgeon. Salary £32 10s. per annum. Applications to Harold A. Mullens, Secretary to the Trustees, Halesworth. (See Advt.)

Appointments.

BIRMINGHAM, C. L. M.D.R.U.I., Certifying Surgeon under the Factory and Workshop Act for the Westport District of the county of Mayo.

BONNOMAN, PHILIP, M.D. Edin., a Medical Referee under the Workmen's Compensation Acts 1897 and 1900, and to act for the Central District of the Sheriffdom of Perth.

Births.

KELYNACK.—At Northwood, Middlesex, on February 1st, Violet Kelynnack (nee Violet McLaren, M.B., Ch.B. Edin.), wife of T. N. Kelynnack, M.D., M.B.C.P., of 120 Harley Street, Cavendish Square, of a daughter.

Marriages.

MAURICE—BURDETT.—On Feb. 1st, at St. Stephen's Church, Westbourne Park, Captain George Thelwall, Kinderley Maurice, R. M.C., eldest son of J. Blake Maurice, M.D., J.P., of Lyons House, Marlborough, to Olive, younger daughter of Sir Henry Burdett, K.C.B., of The Lodge, Forchester Square, W.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXX.

WEDNESDAY, FEBRUARY 15, 1905.

No. 7.

Original Communications.

THE TREATMENT OF POST-NASAL ADENOIDS.

By JOHN WARD COUSINS, F.R.C.S., M.D.
Lond.,

Senior Surgeon to the Royal Portsmouth Hospital and the Portsmouth and South Hants Eye and Ear Infirmary.

POST-NASAL adenoids occur very frequently in children. They are variable in size and soft, and they readily bleed on pressure. They develop on all the walls of the naso-pharynx, blocking the orifices of the Eustachian tubes and the posterior nasal apertures, causing habitual mouth-breathing, repeated attacks of chronic nasal catarrh, deafness from disturbance of the middle ear, and also mental and physical depression. The indications for operative interference can generally be recognised more by the persistency and urgency of the symptoms than by the examination of the nose and throat. The removal of these growths can be undertaken without any risk, provided there is no active disorder or any impairment of the health. After an attack of tonsillitis or catarrhal inflammation of the naso-pharynx, it is always desirable to defer the operation for a few days.

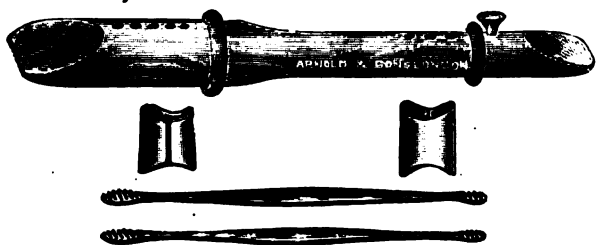


FIG. I.

Now, with reference to the mode of operating, some surgeons use curettes of many forms, while others prefer a steel finger-nail, or post-nasal forceps. In children the best instrument is the sterilised finger-nail, as it can be safely employed both to define and remove the growths in the obscure recesses of the naso-pharynx, guided by the sense of touch. I very seldom use a curette, although it is sometimes necessary in the removal of the firmer adenoids which are found in older patients.

In my operations upon children I use only the simple contrivance represented in Fig. I, and with these I have cleared the naso-pharynx in hundreds of cases, and I have had very seldom, if ever, to repeat the treatment.

The mouth-gag is a short rod of hard wood, carrying a wooden ring to regulate its insertion between the teeth, and one end of it is larger than the other, to suit the capacity of different mouths. The metal rings are simple protectors of the forefingers of the operator, and the nasal probes are made of flexible metal, and are of great utility in clearing the posterior nasal apertures.

After preparing the patient by the frequent application of some deodorising mouthwash, I always carefully examine the teeth, and remove any loose tooth before the introduction of the gag. An anæsthetic is of great assistance in clearing the naso-pharynx, but it requires very careful administration. I prefer A.C.E. or chloroform; but whatever anæsthetic is employed it must only be continued to arrest corneal sensibility, and always short of suspending the reflex actions of coughing and swallowing. As soon as the patient is ready, the head is brought well over the edge of the table, and is there supported by the hands of a nurse or the arm of a surgeon, at the same time the shoulders are raised on a pillow. The nasal probes are passed through the inferior meatuses into the pharynx; the gag is fixed in the right angle of the mouth, and the left forefinger is introduced into the



FIG. II.

pharyngeal fossa, and with it the sides and roof, the Eustachian orifice, and the posterior nasal apertures are rapidly cleared. The gag is then shifted to the left angle of the mouth, and the operation is repeated on the right side with the right forefinger (see Fig. II). The probes are now freely applied around the posterior orifices, and rubbed over the inferior nasal passages. In many cases the hæmorrhage is free, and it is necessary to have some sterilised swabs at hand to wipe the blood out of the mouth and pharynx. After clearing away the adenoids I always excise the tonsils if they are unhealthy and enlarged.

Transient shock sometimes follows the operation, and cases of troublesome hæmorrhage have been reported caused by tearing the mucous surface with forceps.

After the patient has recovered from the anæsthetic, the improvement in the hearing power and breathing is often very marked. As a general rule, I order rest and light and soft food for a few days.

THE VALUE OF BLOOD EXAMINATION IN THE DIAGNOSIS OF MANY CASES.

By WHITEHALL STEVENS, M.D.Lond.,
M.R.C.P.Lond..

Fellow of University College, London; Assistant Physician and Pathologist to the Cardiff Infirmary.

It is only in comparatively recent years that the value of a systematic blood examination in many cases which come under our notice has been sufficiently realised, but I have no hesitation in saying that before many years have passed it will be incumbent upon every scientific practitioner to be trained in so-called "hemianalysis." The technique of blood examination is comparatively simple, the apparatus necessary being a hæmacytometer, a hæmoglobinometer, and the requisites for examination of a blood-film, and in some cases it may be necessary to examine for Widal's reaction, or for the parasite of malarial fever.

In the examination of a given specimen of blood the following points may have to be observed:

- (1) *Red Corpuscles*.—(a) Number per cubic mm.; (b) sizes; (c) shapes; (d) presence of nucleated red corpuscles; (e) amount of hæmoglobin.
- (2) *Leucocytes*.—(a) Number; (b) differential count of different varieties; (c) presence of myelocytes.

(3) *Widal's Reaction.*

In connection with the subject of blood examination, there are two main practical questions to be considered:

(A) *What is the diagnostic significance of certain alterations in the blood?*

(B) *In what classes of cases met with is a blood examination indicated?*

(1).—*Alterations in Connection with Red Corpuscles.*

(a) *Number*.—The average number of red cells per cubic mm. is about 5,000,000.

A diminution in number is spoken of as oligocythæmia, and this condition is met with under many circumstances:

(i) In chlorosis an average count is about 4,000,000, but it may be much lower. In this affection the "anæmia" present depends more upon a reduction in the hæmoglobin than in the number of red cells ("chlorotic type" of anæmia).

(ii) In pernicious anæmia one finds the lowest blood counts, and an average is about 1,500,000, though it may be considerably lower. In this affection the "anæmia" present depends more upon a reduction in the number of red cells than in the amount of hæmoglobin, and indeed the so-called "colour-index" is raised.

(iii) In secondary anæmia the blood counts vary very widely. Anæmia is, of course, a feature more or less marked of most diseases, but I will content myself with mentioning a few of the more important forms of secondary anæmia:

(A) In post-hæmorrhagic anæmia an average

count is about 2,500,000, and even after exceedingly severe bleeding the count is rarely below 1,500,000.

(B) In leukæmia an average count ranges from 2,500,000 to 3,500,000, and the same may be said of Hodgkin's disease.

(C) In splenic anæmia the average is over 3,000,000, and in many cases the count is little, if at all reduced.

(D) In malignant disease the count is usually lowered, an average being about 4,000,000, but in some cases, especially in cancer of the stomach, the count is often much lower, though it rarely falls below 2,000,000.

(E) In ankylostomiasis the count may be very much lowered.

(b) *Size of red cells*.—The average diameter of the red cell is 7.5 mm. (mm. = $\frac{1}{16000}$ inch). Under normal circumstances the diameter may range from 6 to 9 mm. Smaller cells than above are called microcytes. Larger cells than above are called macrocytes.

Very large cells (12 to 16 mm.) are called megalocytes. Both macrocytes and microcytes are found in the various forms of anæmia, and the more severe the anæmia the more abundant they are. The presence of megalocytes in large numbers is suggestive of pernicious anæmia.

(c) *Shape of red cells*.—In some cases the red cells show peculiar and abnormal shapes (ovoid, rod-like, flesh-shaped, &c.). Such changes are spoken of as poikilocytosis. Poikilocytosis indicates simply a high degree of anæmia, and it may be met with in anæmia from any cause; nevertheless, it is especially pronounced in pernicious anæmia and in severe cases of chlorosis.

(d) *Nucleated red cells*.—To demonstrate the presence of these cells it is necessary to have dried and stained blood preparations. Two varieties of nucleated red cells are recognised:

(i) *Normoblasts*. These are nucleated red cells of the size of ordinary red corpuscles. Normoblasts may be found in all forms of severe anæmia.

(ii) *Megaloblasts*. These are very large nucleated red cells (11 to 20 mm.).

When these cells are found in the blood in considerable numbers they point to pernicious anæmia. In small numbers they sometimes (though rarely) are found in other forms of severe anæmia.

(e) *Hæmoglobin*.—The so-called "colour-index" of the red cell is the relation of the percentage of hæmoglobin to the percentage number of red cells. Thus, with a hæmoglobin percentage of 60 and a red cell, and a red cell percentage of 80, the colour index is $\frac{60}{80} = \frac{3}{4} = .75$.

The percentage of hæmoglobin is diminished in all cases of anæmia (primary or secondary), though the colour-index may be normal, lowered or raised:

(i) In pernicious anæmia the colour-index is always raised, an average index being about 1.5, or, in other words, the diminution in hæmoglobin is not proportionate to the decrease in the count of the red cells (each individual corpuscle is richer in hæmoglobin).

(ii) In chlorosis the colour-index is always lowered, an average being about .7, or, in other words, the diminution in hæmoglobin is out of proportion to the decrease in the count of the red cells (each individual corpuscle is poorer in hæmoglobin):

(iii) In splenic anæmia the colour-index is lowered, an average being about .6 ("chlorotic type" of anæmia).

(iv) In other forms of anæmia the colour-index is either normal or, what is more common, slightly lowered.

(2).—*Alterations in Connection with the Leucocytes.*

(a) *Number.*—The number of leucocytes in normal blood is on an average 7,000 per cubic mm., though they may vary within physiological limits from 5,000 to 10,000.

(b) *Differential count.*—The following varieties of leucocytes are distinguished:

(i) *Polymorphonuclear neutrophiles.* These constitute the bulk of the leucocytes found in normal blood (60 to 75 per cent.).

(ii) *Eosinophiles.* These number 2 to 4 per cent.

(iii) *Small lymphocytes.* These number 20 to 30 per cent.

(iv) *Large lymphocytes.* These number about 5 per cent.

(v) *Myelocytes.* These are never found in normal blood.

An increase in the number of polymorphonuclear leucocytes is termed polymorphonuclear leucocytosis; an increase in the number of lymphocytes is termed lymphocytosis; an increase in the number of eosinophiles is termed eosinophilia; the presence of myelocytes is termed myelocytosis.

In regard to leucocytosis it is necessary to remember that this condition to a certain degree may be present in health under various circumstances, and we thus have to distinguish between physiological and pathological leucocytosis.

Physiological Leucocytosis.

This affects mainly the ordinary polymorphonuclear leucocytes, and it may be found under the following circumstances: In the new-born infant, in pregnancy, after exercise, after cold baths, and after the passing of food (the count rarely rises above 16,000).

Pathological Leucocytosis.

(a) *Polymorphonuclear leucocytosis.*—This is the ordinary form of leucocytosis. Its causes are as follows:

(i) In most acute infectious diseases except measles, typhoid fever, influenza, and tuberculous disease (unless suppuration be present).

(ii) In acute inflammatory affections, such as pleurisy, peritonitis, appendicitis, &c.

(iii) In suppuration from any cause.

(iv) In some cases of malignant disease.

(v) After hæmorrhage.

(vi) In various forms of "secondary" anæmia there is often a moderate leucocytosis.

(vii) In leukaemia (*see below*).

(b) *Lymphocytosis.*—In this the lymphocytes are present in increased numbers. Lymphocytosis may be "absolute" or "relative":

Absolute lymphocytosis.—In this the total number of leucocytes is increased, and the increase is most marked in connection with the lymphocytes. This condition is characteristic of lymphatic leukaemia.

Relative lymphocytosis.—In this the total number of leucocytes is not increased, but the relative percentage of lymphocytes is raised. This condition is found normally in infants, and

is also found in many diseases (pernicious anæmia, syphilis, &c.).

(c) *Eosinophilia.*—This condition may be met with under the following circumstances: (i) In association with intestinal parasites—trichinosis, ankylostomiasis, &c. (ii) In many skin diseases, e.g., pemphigus and eczema. (iii) In spleno-medullary leukaemia. (iv) Occasionally in other affections, such as asthma and phthisis.

(d) *Myelocytosis.*—The presence of myelocytes in the blood is always pathological. Myelocytes when found in large numbers, together with a great increase in the total leucocyte count, are characteristic of spleno-medullary leukaemia. In small numbers they may be found in severe cases of anæmia (pernicious anæmia, chlorosis and secondary anæmias).

Leukopenia (a decreased leucocyte count).—The conditions under which may be found an absence of leucocytosis, or an actual diminution, are splenic anæmia, typhoid fever, measles, influenza, malaria, miliary tuberculosis, and all tuberculous affections unattended by suppuration.

(3).—*What is the Clinical Value of Widal's Reaction?*

Since an examination for the presence of Widal's reaction has become an important factor in the diagnosis of typhoid fever, the question of its real clinical value is of much importance, and in this connection the following points must be remembered:

(a) The reaction is present in about 97 per cent. of all cases of typhoid fever, and is found in over 90 per cent. of cases tested before the ninth day.

(b) The reaction is usually obtained by the seventh day, and has been noted as early as the third or fourth day.

Although in most cases the reaction appears before the fourteenth day, it may be much delayed, and only make its appearance about the twentieth day, or later still.

(c) The reaction may disappear when the temperature becomes normal, or it may persist for weeks, months, or even for many years.

(d) The reaction is sometimes "intermittent." If, therefore, a negative reaction be obtained in a supposed case of typhoid fever on the eighth or ninth day, either the diagnosis is wrong or the reaction is delayed, or, perhaps, it is intermittent, or possibly it is one of those very rare cases of typhoid fever which do not give the reaction.

If a positive result be obtained, it may be concluded that the person either has typhoid fever, or that he has previously had the disease, and this point is important, as a patient may have the disease in a mild form or he may have had typhoid fever previously, with a persisting reaction. I may say in this connection that I have known of a case of appendicitis giving a well-marked Widal's reaction, and it is only reasonable to assume in such a case that the patient has had previous typhoid fever, a history of which is sometimes difficult to obtain, as he may have suffered from the disease in a mild form.

In What Classes of Cases met with is a Blood Examination Indicated?

Having discussed the clinical significance of the various alterations found in the blood it is now necessary to examine the above question.

(i) *There are certain diseases in which a*

correct diagnosis cannot, in many cases, be made without a blood examination. These are:

(i) Some cases of typhoid fever (Widal's reaction).

(ii) Some cases of malaria (malaria parasite).

(iii) Certain peculiar diseases such as pernicious anæmia, chlorosis, splenic anæmia, spleno-medullary leukæmia, and lymphatic leukæmia.

(2) In cases presenting obvious anæmia, and in which the diagnosis is doubtful, a blood examination is of the greatest value.

In practice one commonly meets with cases in which, after inquiry into the history, after a careful consideration of the symptoms present, and after minute physical examination directed to lungs, heart, stomach, spleen, liver, urine, fæces, glands, &c., nothing distinctive can be found, and in these cases a blood examination should never be omitted, and it is especially to be remembered that a case apparently one of chlorosis may really be "secondary" to some other affection, and that one of apparently pernicious anæmia is not uncommonly really "secondary" to some other cause. In these doubtful cases a blood examination may give the following information:

(a) It may point to pernicious anæmia. In this disease the following points may be noted:

(I) Red cells:

(i) Number. This is greatly diminished. An average count is about 1,500,000, though it may be much lower.

(ii) Shapes. Marked poikilocytosis is present.

(iii) Sizes. Variations in size are very common, and megalocytes may be abundant.

(iv) Nucleated red cells are always found, and megaloblasts are present.

(v) Hæmoglobin. The index is raised.

(II) Leucocytes. These are relatively increased in number, but absolutely normal or diminished. A few myelocytes are occasionally found.

In general it may be said that a blood count of below 2,000,000, in the absence of intestinal parasites and of recent profuse hæmorrhage, is most suggestive of pernicious anæmia, and that when in addition to this one finds a raised hæmoglobin index and the presence of both megalocytes and of numerous megaloblasts, the diagnosis is amply confirmed.

(b)—It may point to chlorosis.

In this disease the red cells are diminished in number (an average count being about 4,000,000, though it may be much lower), and the hæmoglobin index is lowered. A blood examination will therefore easily distinguish between chlorosis and pernicious anæmia, and also between chlorosis and those forms of anæmia associated with leucocytosis; but it will not serve to distinguish between chlorosis and some forms of "secondary anæmia."

(c) It may point to spleno-medullary leukæmia. In this there is myelocytosis associated with the anæmia.

(d) It may point to lymphatic leukæmia. In this there is lymphocytosis associated with the anæmia.

(e) It may point to anæmia associated with eosinophilia (intestinal parasites, &c.).

(f) It may point to a "secondary" anæmia.

The red corpuscles are diminished in numbers in all cases of secondary anæmia, but the decrease is often not great (average about 4,000,000, though it may be much lower after severe hæmorrhage).

In cases of cancer of the stomach, although the blood count is often low, it is very rarely under 2,000,000. In secondary anæmias, again, the hæmoglobin index is either normal or diminished, megaloblasts are absent and leucocytosis is sometimes present.

In summing up the chief points under this heading we may mention the following facts:

(i) In pernicious anæmia a careful blood examination will usually point to the nature of the affection.

(ii) In spleno-medullary leukæmia and in lymphatic leukæmia the blood is sufficiently distinctive.

(iii) In chlorosis there may be difficulties in separating the blood condition from that due to "secondary anæmia."

(iv) If leucocytosis be present chlorosis and pernicious anæmia can be excluded.

(v) The presence of eosinophilia may be very suggestive.

(3) In cases with splenic enlargement. It is necessary to remember that splenic enlargement, associated with anæmia, may be present under many conditions, such as malaria, cirrhosis of liver (especially "hypertrophic" cirrhosis, rickets, syphilis, albuminoid disease, tuberculosis, septic conditions, infectious diseases, leukæmia, Hodgkin's disease, and splenic anæmia).

How does a Blood Examination help us in Arriving at a Differential Diagnosis?

Leucocytosis will be present in leukæmia, in septic conditions, in infectious diseases, in albuminoid disease, in tuberculosis (if attended with suppuration elsewhere), and in some cases of Hodgkin's disease.

On the other hand, leucocytosis is absent in splenic anæmia and in malaria.

The association of a large spleen with more or less well-marked anæmia is a feature of splenic anæmia, and many cases of this disease are (without a blood examination) diagnosed as leukæmia. The blood condition in splenic anæmia shows a condition like that seen in secondary anæmia—the red cells are diminished in number, but often not markedly, and the count is sometimes normal. The hæmoglobin index is lowered and sometimes a few nucleated red cells are present and also poikilocytosis. In splenic anæmia the leucocytes are either normal in number or, what is more usual, diminished, sometimes to a marked degree (leukopenia).

(4) In cases with a history of residing abroad or presenting symptoms suggesting malaria such as rigors and sweatings.

It is to be remembered that so-called "ague symptoms" may be malarial in origin, or they may be dependent upon various other affections, such as septicæmia, pyæmia, malignant endocarditis, leukæmia, Hodgkin's disease, suppuration, cholangitis, &c.

In such cases there may also be enlargement of the spleen associated with anæmia.

A blood examination in these cases is of importance, for it may show the presence of the malarial parasite, and again a condition of leucocytosis would be present in all cases not due to malaria.

(5) In cases with pyrexia of doubtful origin. In this connection it is to be remembered that pyrexia may be due to many causes which can be more or less cleared up by a blood examination, e.g.,

typhoid fever, influenza, tuberculosis, septicæmia, malignant endocarditis, pyæmia, suppuration, leukæmia (spleno-medullary and lymphatic), Hodgkin's disease, pernicious anæmia, malignant disease, malaria.

(i) The presence of leucocytosis would be against typhoid fever, influenza, malaria, tuberculosis (without suppuration), and pernicious anæmia. Leucocytosis would be met with in all the other affections, including some cases of malignant disease.

(ii) Widal's reaction would discover typhoid fever.

(iii) Splenic blood conditions would discover malaria, pernicious anæmia, and leukæmia.

(6) In cases suggestive of intestinal parasites. In trichinosis and in ankylostomiasis marked eosinophilia is present. In ankylostomiasis (except for eosinophilia) the great reduction in the red cells may simulate pernicious anæmia.

(7) In cases with glandular enlargement. A blood examination may show at once the presence of lymphatic leukæmia. In Hodgkin's disease there is a reduction in the number of red cells (average about 2,500,000), but leucocytosis is usually absent, though there may be some increase in the number of the ordinary leucocytes in advanced cases.

(8) In certain abdominal conditions. A blood examination for leucocytosis may serve to distinguish between typhoid fever and appendicitis, and between the latter disease and tuberculosis. (In tuberculosis there is no leucocytosis in the absence of suppuration.)

(9) In the diagnosis of suppuration. In acute inflammatory conditions, such as pleurisy, cholecystitis, appendicitis, &c., there is always leucocytosis, but when suppuration has occurred the leucocytosis is much increased. In severe appendicitis without suppuration the count may be up to 20,000 or even 24,000, and thus a count of above that number would point to suppuration. No absolute line can be drawn, but, nevertheless, very marked leucocytosis is very suggestive.

In this connection one point may be mentioned *en passant*; in suppuration round about the diaphragm associated with leucocytosis, it has been stated that the presence of eosinophilia suggests that the suppuration is below the diaphragm rather than above it.

CYSTIC ENDOMETRITIS. (a)

By R. D. PUREFOY, M.D., F.R.C.S.I., &c.,
Late Master of the Rotunda Hospital.

ENDOMETRITIS, either alone or as an attendant on, or complication of, some other pathological condition, claims a large share of our attention in nearly every case of uterine disease; and those who have had the widest experience will be the most ready to acknowledge how often our hopes of speedy, or even steady, improvement are disappointed. Whenever we have regard to the complex structure of the endometrium, and the periodically recurrent variations in its blood supply, on which its functional activity may be said to depend, we shall feel no surprise in observing how often these variations go wrong in excess or deficiency, and thus induce obstinate structural changes. The precise nature of these changes, the

conditions, local, constitutional, and bactericidal, which are potential in causing them, have, as is fitting, engaged the attention of many acute observers with very satisfactory results; but with regard to some forms of endometritis, for instance, that to which I wish to direct your attention to-night, we must confess their etiology is still awaiting elucidation.

I propose to bring under your notice to-night two cases illustrating the history and course of what has been termed cystic endometritis.

CASE 1.—Mrs. F., æt. 45. In fairly good health at time of marriage six years ago; in about seven months afterwards had an early abortion. Some months later, after a long journey, suffered from distressing pruritus vulvæ, which, however, yielded to treatment. In October, 1902, after missing one menstruation, distressing dorsal and abdominal pain was felt, attended with slight intermittent bleeding. Later on the bleeding became continuous, sometimes profuse, and so continued till her admission to the Rotunda in January, 1903. At this time her general condition was such as to warrant the use of medicine, at least for a time, in the hope of arresting the bleeding, and accordingly she was given that most useful uterine hæmstatic, tincture of Indian hemp in 5 minim doses twice daily, with excellent effect. This was followed by the administration of the muriate tincture of iron, and in about a fortnight the bleeding had quite ceased. Examined under chloroform, the uterus was found in normal position, the cervix healthy, and the appendages likewise. The cavity measured $3\frac{1}{2}$ inches; viscid, glairy discharge poured from it in large quantity, and the curette brought away in abundance fragments of greatly thickened endometrium. Subsequently, at intervals of three or four days, she was treated on several occasions with iodine and phenol or pyroligneous acid, and in about three weeks from the date of curetting she was allowed home apparently in a very satisfactory condition. For some months menstruation was normal, but a return of the bleeding rendered a repetition of the treatment necessary twice in 1903, and once this year, 1904, in the month of September. The tissue removed on each occasion, though much lessened in amount, presented the same microscopic characters.

CASE 2.—K. C., æt. 28, married two years; one early miscarriage. Admitted August 8th, 1903, in a very feeble condition owing to repeated bleedings; indeed, her aspect made me apprehend the presence of malignant disease.

When some improvement in her general condition had been effected by rest, feeding and tonics, she was examined, and the uterus found to be retroverted and somewhat fixed by numerous adhesions; the appendages were not reached. When dilated and curetted the amount of pulpy tissue removed was so great that I thought my apprehensions as to malignant disease were only too well founded; but examination by my much lamented friend, the late Dr. Neville, showed only the characteristic appearances of cystic endometritis. This woman was re-admitted a few months later, when it was found necessary to repeat the treatment.

The main points in these two interesting cases may be thus summarised:—

1. Both women were married, not advanced in years, and free from other disease.

(a) A Paper read before the Obstetrical Section of the Royal Academy of Medicine in Ireland, February 3rd, 1905.

2. Both had been at least once pregnant before the development of this uncommon disease.

3. Bleeding without any considerable pain was the prominent sign in both cases.

[Having regard to the marked tendency to recurrence, and the severe bleeding which attends this disease, one feels inclined to describe it as a transitional stage between benign and malignant adenoma.]

4. Recurrence took place at an early date.

5. The microscopic appearances are not like those of malignant disease, especially as regards the epithelium.

It may be urged that more vigorous use of the curette in the first treatment would have prevented recurrence, but in my opinion it is better to err in removing too little than to run the risk of rendering the endometrium permanently incapable of fulfilling its highest function, by too extensive removal of its glands.

Though the experience of only two cases is inadequate to warrant positive statements on the matter, I incline to the view that curetting, repeated if necessary, and followed by the application of the caustics commonly in use, will effect a cure.

For the safe and effective use of the latter I think we are still in want of a safe apparatus. A syringe for intra-uterine injection should be so constructed that the fluid may be measured by drops, and I have not seen one which fulfils this indication. Many years ago Dr. Barnes suggested an apparatus for carrying medicated ointments into the uterine cavity, and recently Dr. Duke has constructed an ingenious appliance by which small quantities of any caustic fluid may be safely diffused in the uterine cavity. For us in Dublin, it is, I think, of much interest to recall the fact that a Master of the Rotunda Hospital, Dr. Evory Kennedy, was the first in Europe to devise a syringe for intra-uterine use.

In cystic as in every other form of endometritis, the first and perhaps the most important indication to be fulfilled in treatment is to secure a sufficiently patulous condition of the cervical canal to admit of free escape of healthy and unhealthy discharges.

As to the choice of caustics, opinions will be found to vary widely. With regard to phenol it is well to bear in mind the narrowing of the cervical canal which is very apt to follow its repeated use, unless well diluted. I think glycerine more suitable as a diluent than spirit or water. In my own practice I have discontinued the application of caustics immediately after curetting, unless in cases of undoubted malignancy.

NOTES ON THE OCCURRENCE OF SUDDEN DEATH. (a)

By A. COCHEZ, M.D.,

Professor of Clinical Medicine at the Faculty of Medicine of Algiers.

THE occurrence of sudden death opens up many obscure problems, but is nevertheless an extremely important department of medical investigation, interesting, as it does, the physician, the physiologist, and the medico-legalist. We are far from being able to explain every case of sudden death, even after the most carefully-performed autopsy, that is to say,

hypotheses based merely on the circumstances of the death and the examination of the corpse often leave us in the dark.

As a general rule, when a medical man is asked to formulate an opinion as to the cause of death in a given case of the kind, he usually invokes aneurysm of the aorta, cerebral congestion or embolism. Now, as Brouardel remarked, aneurysm is an extremely rare cause of sudden death, since he only met with it four times in a thousand instances, while cerebral congestion (not to be confused with hæmorrhage) never once caused it. Embolism is credited with causing sudden death far too lightly, in oblivion of the fact that its existence implies a source of origin, a local lesion, capable of determining the formation of the clot (thrombosis, cardiac and arterial lesions), that pulmonary and cardiac emboli are alone capable of determining sudden arrest of life, and that in such case the symptoms preceding the fatal attack present characteristic features.

Cerebral embolism is not a cause of sudden death. It causes a local lesion, accompanied or not by an apoplectic attack; but it does not entail the functional suppression of a large cerebral area, the circle of Willis forming a vast anastomosis between the arteries of the brain, which secures a certain circulatory intercommunication between the most important encephalic segments.

For many years we were accustomed to rely on Bichat's "vital tripod" to explain death, it being always attributed to changes in one of the three essential organs of life, *viz.*, brain, heart and lungs. Brouardel referred death to the brain, heart or kidney, and the functional importance of the last-named organ has been brought into prominence during the last few years, the part played by the renal filter in physiology and pathology, and the importance of auto-intoxication in nephritis being at present universally recognised.

In short, we may affirm that sudden death is due to a cause capable of suddenly arresting the respiratory or circulatory function, acting, it may be, either directly on the heart, or indirectly through the nervous centres. This sort of inhibition may be brought about by numerous diseases, the commonest being those of the heart, the brain (or rather, the encephalon), and especially of the kidneys, the latter acting by the mechanism of intoxication. Uræmia, then, is the principal factor in the causation of sudden death, hence the importance of diagnosing and averting this intoxication, the more so seeing that it often supervenes insidiously without any outward manifestation likely to give warning.

A case in point was admitted the other day into Dr. Sabadini's service. The patient was an agricultural labourer, æt. 33, suffering from a suppurating inguinal lymphatic gland, consequent upon numerous erosions of the skin of the thigh and leg. The abscess had burst spontaneously, and there was very little discharge, the neighbouring tissues were thickened, but not very tender, and his general health appeared satisfactory. There was no cardiac murmur, and the lungs revealed no lesion of any kind, and the urine was free from albumin and sugar. Things ran their course until twelve days after admission, when he was suddenly seized with stertorous breathing, accompanied by slight, fugitive, convulsive movements of the right arm. The left pupil was dilated, the right contracted. The heart rapidly failed, and in about two minutes he was dead. At the *post-mortem* examination the brain was the seat of diffuse congestion; there was no definite lesion, but the heart was enormously hypertrophied, weighing 700 grammes. The myocardium was yellow, hard and resistant. The valves were healthy, the aorta was not thickened, and the coronary arteries were healthy. The right kidney weighed 160 grammes, and the left 162 grammes. On section it was highly congested, the cortex was obviously thinned, it was hard on section, and the glomeruli, visible to the naked eye, stood out prominently as red points, while the pyramids of Malpighi were white and dense.

These cases of fulminating uræmia, though rare, are

well known. Professor Fournier published the first indisputable case seen by him a few years previously in England. An individual was seized with malaise in the street, he entered a chemist's shop, where he was given a draught and fell dead on the threshold. The passers-by jumped to the conclusion that the chemist had poisoned his customer, and wrecked the shop. The body was removed by the police, and the coroner ordered a *post-mortem* examination, when he was found to present signs of advanced Bright's disease.

We must now ask ourselves under what circumstances uræmia causes sudden death, in other words, what are the precipitating causes of sudden death in uræmia. It must be confessed that in many instances the proximal cause escapes us, but not infrequently we are enabled to incriminate some error of diet, some intoxication of external origin, excessive fatigue—all circumstances that tend to the accumulation of toxins in the organism.

I remember the case of a journalist who, after a hearty meal, adjourned to a brothel. Already more or less under the influence of alcohol, he paid for champagne all round, and finally went upstairs with one of the inmates. Later on he passed a motion in bed, and the girl, disgusted, ran off, leaving him alone. Next morning he was found dead at the foot of the bed, the left side of the body covered with ecchymoses. Naturally the police were called in, and the body was taken to the morgue, where he was discovered to have granular kidneys. The champagne he had drunk had poisoned him, because he was unable to eliminate it, and he had succumbed to a uræmic convulsion.

Years ago, when I was house surgeon in the Children's Hospital, I remember being called to one of the porters who had been seized with a severe attack of dyspnoea. After a cursory examination I took him to be suffering from ordinary asthma, and gave him a hypodermic injection of morphia (1-10 grain). Two hours later he was cyanosed, cold, and apparently *in articulo mortis*, and careful examination showed us that he had nephritis with toxic dyspnoea. The moral to be drawn from this case is the necessity for extreme caution in the administration of drugs to the subjects of Bright's disease, especially active drugs, such as salicylic acid, salts of mercury, salts of potash, opiates and all alkaloids. Consequently, it behoves us to examine the urine of all patients very carefully before venturing to prescribe for them. I may remind you, too, that the external application of certain drugs is not free from risk. Dressings containing carbolic acid, corrosive sublimate, iodoform, &c., have often caused serious disturbances even in non-renal patients, and for this reason, surgeons, preferring asepsis to antiseptics, tend more and more to employ nothing stronger than boiled water.

In Dr. Sabadini's case, death supervened with lightning-like rapidity without any apparent cause in an individual under treatment for suppurating adenitis, who was suffering from latent Bright's disease without albuminuria. We may ask ourselves whether the iodoform dressings, renewed daily, may not have provoked acute intoxication in this patient, especially as he was already suffering from auto-intoxication consequent upon the inadequate elimination of poisons *vid* the kidneys. This case, too, reinforces the lesson that methodical, careful medical examination of the patient, completed by urinary analysis several times repeated, is indispensable if we wish to diagnose and avert the consequences of latent nephritis, failure to recognise the existence whereof exposes our patients to unexpected and fatal accidents.

Trinity College, Dublin, Hilary Term, 1905.

Final Examination, Section A.—Gustav W. Thompson, William Hutchinson, Richard A. Connell, Malcolm K. Acheson, Archibald L. Robinson and Theodore C. Somerville (equal), Charles G. Sherlock, Henry D. Woodroffe, Wilfred L. Hogan, Langford V. Hunt, Herbert J. Wright, Francis O'B. Kennedy.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON. MEETING HELD FEBRUARY 10TH, 1905.

The President, DR. FREDERICK TAYLOR, in the Chair.

DR. WILLIAM EWART described a case of
SOFT-VALVE MITRAL STENOSIS IN WHICH NO MURMUR
WAS HEARD,

in a woman, æt. 45. The existence of mitral stenosis was not suspected until it was found in the heart, which was exhibited. The clinical value of the case lay in the undoubted character of the lesion, and in the independent testimony of various observers, during a long period of hospital treatment, as to the absence of murmurs, demonstrating the fact that the characteristic bruits may sometimes be in abeyance for prolonged periods at an advanced stage, though more often in abeyance for short intervals only at an early stage. The anatomical features of the lesion, of special interest in connection with this latency, were fairly described by the term "soft-valve stenosis," which might be of use in defining a separate type of lesion in which the early fibrous changes did not, as in the "hard-valve stenosis," develop into progressive thickenings and indurations. The action of a relatively soft stenosed mitral valve must be different from that of the rigid stenosis, particularly when, as in this instance, the chordæ tendinæ and the papillary muscles were quite free from stiffness, shortening, or fibrosis. The absence of murmur where this complication was also absent might, perhaps, if observed in other cases, be an argument in support of the prevailing view as to the auriculo-systolic mode of production of the presystolic mitral murmur, and as to the share of damaged chordæ in occasioning diastolic murmurs.

DR. SEYMOUR F. TAYLOR said that mitral stenosis was the most interesting of the cardiac lesions. Its murmur was the most difficult one to time; its mode of production was not yet settled; its frequency since Gardner's paper had been well recognised. It was known that the timbre, intensity and time of the murmur depended on the strength of the heart wall. It was possible that, in Dr. Ewart's case, the murmur had been present at a time prior to observation, so that its absence was due to the mural condition. In support of this was the dilatation of the left auricle and the fatty state of the wall. He suggested that the thinness of the valve was due to an acute inflammation softening the endothelium and subjacent tissues. Had there been any pyrexia to indicate endocarditis? He thought that rheumatism causing endocarditis before puberty produced stenosis, whereas in other people it produced regurgitation; in other words, that the size of the ring was fixed by early disease, and so led to stenosis late.

DR. PARKES WEBER referred to a case of undoubted calcified stenotic valves in which the stenotic murmur had been absent for some time.

DR. PASTEUR asked whether any alteration of rhythm that is so common in stenosis cases had been observed, and also whether the first sound at the apex was suggestive of stenosis. He speculated on the relation between the clinical signs and the condition of the chordæ tendinæ.

DR. WYNTER did not think that mitral stenosis could occur in children, certainly not before the age of seven. He held that stenosis in adults was the result of a persistence of the infantile size of the ring. Nearly half of the cases of mitral stenosis that he had seen gave no history of rheumatism, which emphasised the frequency with which rheumatism was overlooked. Thickening of the valve was due to the repeated attacks of rheumatism, and perhaps the thinness of the valve in Dr. Ewart's case was due to the absence of more than one such attack.

DR. HAWKINS referred to the case of a woman who was in hospital for a month with nervous symptoms, and who died suddenly from thrombosis of the

abdominal aorta. *Post-mortem* was mitral stenosis, which had during life revealed no evidence of its existence.

Dr. FREDERICK TAYLOR showed how the murmur varied according to the two factors, the driving force and the kind of obstruction. In Dr. Ewart's case there was indisputable obstruction, so that absence of murmur could only have been due to weakness in the driving force. Temporary disappearance of the murmur was a very familiar occurrence, and he could recall numerous instances of it. In these cases he had seen *post-mortem* both soft valves and stiff valves.

Dr. EWART, in reply, said that there had been no such pyrexia in his case as would indicate endocarditis. The first sound was short and weak, but not tapping, as is usual in mitral stenosis. A cantering rhythm had been present at times. He agreed that the driving force must have been deficient, but insisted that the softness of the valve was an important factor in causing the absence of murmur. He did not know whether any murmur had been present before the case came under his observation. He did not think that adult stenosis was due to a persistent infantile ring.

Mr. E. PERCY PATON described a case of

ACCESSORY THYROID IN A GIRL, ÆT. 16.

The patient had noticed a swelling on the side of her neck in the submaxillary region for some months before coming under observation. It gave her no pain, but she was certain that it was increasing in size. It was situated in the right submaxillary triangle and could be felt from inside as well as from outside the mouth. The diagnosis before operation was uncertain, but on microscopical examination after removal it was shown to consist of thyroid tissue. A microscopical section was shown. Some points were then referred to as to the usual seats of accessory thyroids.

Mr. WALTER SPENCER referred to the researches of the late Professor His on the development of the thyroid gland. In one of the diagrams, taken from His' monograph, which he showed, an explanation of the mouth origin of that form of accessory thyroid was indicated. It was clear that it must have originated from the central part of the thyroid, *i.e.*, the thyroglossal duct, because of its position above the mylohyoid muscle. It was important to remember, when the question of operation arose, that the accessory thyroid may be the only representative of the gland, so that its removal would mean myxœdema. This had several times been caused in this way, there being no lateral lobe present.

Mr. PATON also pointed out that a lingual thyroid might be the only part of the thyroid present. Removal of part of the mass, however, usually led to a recurrence.

Mr. HENRY BETHAM ROBINSON read a paper on
EXTRA-PERITONEAL URETERO-LITHOTOMY IN A CHILD,
ÆT. 3.

The child upon whom this operation was performed was admitted to the East London Hospital for Children on June 17th, 1904, with an impacted calculus in the urethra. On examination, after this stone had been extracted, there was felt bi-manually a small hard lump on the left side of the pelvis just below its brim, which was diagnosed as an impacted calculus in the ureter. The corresponding kidney did not appear to be enlarged. After waiting a few days for the urethral wound to heal, and to see if the stone was making its way to the bladder, which it did not do, ureterolithotomy was performed and a small oval calculus removed. A fine catgut stitch was put through the outer part of the ureter and a wick drain left in the wound. There was very slight leaking for three days; after that the wound healed rapidly. There was no blood in the urine after the operation. From an experience of three cases, two in the adult and this child's, Mr. Robinson considered this to be an easier operation in the child for the following reasons: the small quantity of fat in the abdominal wall and subperitoneal connective tissue, and the shallow pelvis with the abdominal position of the bladder; the latter enabled the finger in the rectum to push the ureter with the impacted stone well up into the wound.

Mr. DOUGLAS DREW described a case of
CALCULOUS ANURIA IN A CHILD.

A male child, æt. 4, was admitted into hospital with stone in the bladder and cystitis, for which suprapubic cystostomy was performed and the bladder drained. After the operation, the child did not make good progress; the pus persisted in the urine, and there were occasional rises of temperature, and the wound did not completely heal. The child occasionally complained of pain in the abdomen, but nothing definite was found after repeated examinations except slight tenderness over the left kidney. This symptom, together with the persistence of the pyuria and irregular attacks of pyrexia, led to the diagnosis of septic trouble in the left kidney. At the end of four months, the child was seized with severe pains and a stone was found impacted in the meatus and was removed. After this, marked improvement occurred; the sinus closed, the temperature kept normal, and the condition of urine greatly improved. A month later, the child began to be sick, pain recurred in the abdomen, the urine again became alkaline, and contained pus and blood, and the wound above the pubis again began to leak; so that the quantity of urine, which had been measured daily, diminished from 25 ozs. to from 7 to 19 ozs. Two radiographs taken at intervals of a few days about this date gave negative results. A few days later, the abdominal pain became more severe, and for the first time was referred to the left inguinal region. The vomiting had increased to several times daily. Examination under chloroform: The left kidney was enlarged, the right could be felt, but not enlarged, by the rectum. Stone of triangular shape felt in the left ureter high up just below the brim of the pelvis. The left kidney was at once exposed and opened, when a calculus was found and removed. The incision was extended forwards, and the calculus in the ureter manipulated up along it and removed by incising the ureter just below the pelvis. The right ureter could be distinctly felt through the wound, and was enlarged; this was the first positive sign of trouble on the right side as the stone which *post-mortem* was found in the lower end of the right ureter had been missed on palpation *per rectum*, and there had been entire absence of symptoms on the right side. The child's condition did not permit of exploring the right kidney at the same time as the stones were removed from the left side; and although the child lived six days after the operation, the condition did not permit of any further interference. The sickness persisted, drowsiness increased, and the quantity of urine *per urethram* gradually diminished until only 2½ ozs. were passed during the last three days. The chief point of interest in the case was the difficulty in diagnosis owing to the negative results of radiography and the very slight degree of pain occasioned by the stones, although from the condition of the ureters, as shown in the specimen, the stones must have been lodged in them a long time. The case is extraordinary in that calculi were removed from the bladder, urethra, left ureter, and kidney.

Mr. PATON referred to a case of a child he had seen in Great Ormond Street Hospital, which had died with anuria a couple of days after an operation for cleft palate. *Post-mortem*, a stone blocking one ureter was found, though during life there had been no evidence of this in the urine or elsewhere.

Mr. ROBINSON said that the experience of all operators was against closing the wound after ureterotomy without drainage.

OPHTHALMOLOGICAL SOCIETY OF THE
UNITED KINGDOM.

MEETING HELD THURSDAY, FEBRUARY 9TH, 1905.

JOHN TWEEDY, P.R.C.S., President, in the Chair.

Mr. EDGAR STEVENSON read a paper on "Exostosis of the Orbit." The patient was a girl, æt. 22, first seen on November 20th, with left proptosis, well marked downwards and outwards, first noticed six months previously; increase rather rapid. She had

no pain except an occasional neuralgic twinge; the eye movements were unimpaired, the vision normal, and no diplopia. Under chloroform a small, hard mass was felt lying under the outer and upper margin of the orbit. On December 10th the tumour was cut down upon and found much larger than was expected. It was attached to the inner angle of the orbit, with its base in the frontal sinus, and it extended right across the roof of the orbit. A dense shell of bone covered cancellous tissue, so that two drills were broken in an attempt to get into it; however, a small piece was removed with a chisel and showed its structure. It was found that the attached base was not very broad, and with a pair of bone-forceps it was wrenched away without difficulty. It is an irregular pear shape, weighing 351 grains, measuring $1\frac{1}{2}$ inches by $1\frac{1}{4}$ inches, by $\frac{1}{2}$ inch. The patient made an excellent recovery, and there is no eye affection whatever.

Mr. A. OGILVY related a case of large exostosis of the orbit. The patient was a healthy man, *æt.* 24, with a good personal and family history. He was first seen in November last complaining of epiphora. A large, hard mass was felt in the orbit on the right side, evidently attached to the nasal side. The tumour was causing myopia and some choroidal changes. On January 1st, 1905, the tumour was found to have two pedicles, and proved difficult to remove. The patient made an interrupted recovery, but diplopia was present; this, however, passed off in two weeks. The questions which this case raises are these: (1) What has to be done with his disorganised lachrymal apparatus? (2) Did the tumour cause the myopia, which has now disappeared, the vision being normal? (3) Are these due to hereditary syphilis, as stated by Charles Stedman Bull? It is curious that so large a tumour could exist in such a small space as the orbit without causing more damage and discomfort than it did.

Mr. WRAY read a paper on "The Treatment of Tobacco Amblyopia." He divided the cases into three groups: (1) Those with amblyopia only; (2) those with amblyopia and tachycardia; and (3) those with tachycardia only. In view of the tendency to cardiac failure, the pulse should always be examined. He had recently seen cases where the pulse ranged from 96 to 135, and patients suffering from tobacco poisoning should be warned that tachycardia might develop. The amblyopia usually disappears if taken early, but by all the recognised treatments recovery was a slow process. As regards the tachycardia, he had seen several cases where it had persisted even after tobacco had been given up for years. He alluded to the toxic breath which was always present with amblyopia, but never when tachycardia was the sole symptom. He ascribed the amblyopia as probably due to saturation of the blood with tobacco alkaloids, and the tachycardia as due to injury or destruction of the cardio-inhibitory neurons of the trachea and bronchi. He thought that bad teeth and a catarrhal condition of the alimentary and respiratory tracts aided the absorption of the poisons. Being much dissatisfied with the orthodox treatment with potassium iodide and strychnine, and considering that nicotine was freely soluble in water, he had seen great and rapid improvement follow from the following treatment:—The patients were directed to dress warmly and drink a pint of water at 7 a.m., and walk briskly for thirty minutes in the open air. Then to drink a second pint and go for a similar walk. Then rest for a few minutes and take breakfast. A third pint is to be taken in the middle of the morning, and a fourth in the middle of the afternoon. Some have even continued to smoke as much as a quarter of an ounce a day, and in three cases practically normal vision was restored in fourteen days. As regards the effect of the water treatment on the heart, the author had not had the opportunity of trying it on the new cases he had lately seen, for this had not been a marked symptom in them, but unquestionably the accelerated beat he had noticed had not disappeared in the same way as the amblyopia. There was considerable doubt as to the method in which nicotine was eliminated, but he thought that it

was mostly by the kidneys, though the lungs and skin probably bear a share. The water treatment had the advantage of utilising all three ways.

Messrs. E. TREACHER COLLINS and RAYNER D. BATTEN read a paper on

NEURO-FIBROMA OF THE EYEBALL AND ITS APPENDAGES.

The case which formed the basis of this case was a girl, *æt.* 14, who had been under Mr. Batten's observation for three years. The right eye was buphthalmic with vision of 1-60. There was also much hypertrophy of the upper lid. There was a doughy swelling over the right temporal fossa. The condition dated from birth. This unsightly eye was excised, together with a wedge-shaped piece of the upper lid. The microscopical condition of the lid showed it to be a case of congenital elephantiasis associated with plexiform neuroma. The chief interest centres in the eye, for it is the fourth case recorded in which neuro-fibroma of the eyelid has been associated with a buphthalmic eyeball. This condition, however, does not seem to be due to fibromatosis of the ciliary nerves, but to increase of tension due—as in another case recorded by Mr. Collins—to congenital adhesion of the root of the iris to the back of the cornea. The terminal nerves in the cornea were, however, thickened. The condition seen in the choroid has not before been noted. Throughout its structure was denser than normal, and in parts it was considerably thickened. It was chiefly composed of fibrous tissue, highly nucleated, with pigment cells present, and very few blood-vessels. Numerous small oval bodies presented the appearance of enlarged nerve endings. By comparison with the other cases recorded it was shown that all portions of the ciliary nerves supplying the eye may be affected with congenital fibromatosis; and that the uveal tract, like the skin, may be affected with a general hyperplasia of the fibrous tissue, though the extent of the affection varies. In some only the terminal filaments and end organs are involved, and in others the larger trunks are also affected.

HARVEIAN SOCIETY OF LONDON.

CLINICAL MEETING HELD AT THE STAFFORD ROOMS, JANUARY 26TH, 1905.

MR. JAFFREY in the Chair.

Dr. J. J. PERKINS showed a man suffering with Addison's Disease. There were pigmented spots on the skin and in the mouth. There had been faintness on micturition; no vomiting.

Dr. WINSLOW HALL remarked on the asymmetry of the thorax which he had observed in another case. This was thought to be only a coincidence.

Dr. J. J. PERKINS also showed a young man suffering from Bronchiectasis, who had been much improved by tracheal injection of creosote in oil. He had gained in weight. Dulness was extensive at the left base; the heart was displaced. Only a few *râles* were now heard. Clubbing of fingers.

Mr. JAFFREY remarked upon drainage in these cases.

Dr. PERKINS thought it was only of use where there existed a large basal cavity, and not in presence of several small cavities.

Dr. BATTY SHAW showed a patient with Recklinghausen's Disease associated with Dilated and Dropped Stomach. W. G., *æt.* 27, a French polisher, for the last three or four years has been troubled with some attacks of pain in the right loin, radiating round the back and down to the right testicle. In twelve months he had lost a stone in weight. When first seen at University College Hospital in February, 1904, he had bad appetite, pain, and vomiting; a slight increase of the stomach noted in the left axilla and a slight splash in the left hypochondrium; the skin was somewhat pigmented and some small flat moles were noticed on the abdomen and near the axilla. The patient was admitted under the care of Dr. Sidney Martin. The pains continued, requiring morphia; the radiographic examination for renal calculus was negative; the urine

was quite normal; examination under an anæsthetic revealed nothing. Mr. Godlee then saw the patient and discovered on the body and head twenty to thirty small subcutaneous masses which caused pain on pressure; two were excised and found to be fibromata lying in close relation to nerves. A few days ago the patient was again examined. The pigmentation and flat warts had increased. In addition the stomach was found to be lying in the suprapubic region; it was greatly distended and when in peristalsis caused severe colicky pain. No tumour could be felt.

Case was discussed by Mr. JAFFREY, and Dr. SUTHERLAND inquired as regards treatment of the condition. It was proposed to hand the case over to the surgeon.

Mr. LAMING EVANS showed a case of severe multiple deformity in a girl, æt. 14, following infantile paralysis at fourteen months, which had received no treatment. Besides a severe lateral deviation with rotation of the spine, a bulging of the anterior abdominal muscles, and a double calcaneo-cavus, all of paralytic origin, there was a contracture at the hip-joints of 135°. As a compensatory curve, the degree of lordosis was extreme. As the ileo-psoas on the right side was active, it was hoped that the child would be able to walk after the deformities had been corrected, and a suitable appliance fitted.

Dr. GUTHRIE thought this was the most severe case he had seen after infantile paralysis. He was not sanguine that any beneficial results would follow from the use of electricity.

Mr. LAMING EVANS showed a case of a man, æt. 60, with a rupture between the long head of the biceps cubiti and its tendon. The long tendon could not be felt, but that of the short was well defined, and by means of this tendon all the functions of the whole muscle were well carried on, but with somewhat diminished vigour. There was no displacement of the head of the humerus.

Mr. JAFFREY thought the short head was torn.

Mr. E. PERCY PATON related the case of an acrobat who had ruptured several muscles in succession through attempting various feats. In some cases of rupture of the short head of the biceps the patient was hardly conscious of the occurrence.

Dr. MAURICE SQUIRE showed a man, æt. 31, a dust-man. *History*: Right otorrhœa all his life; gonorrhœa and sores, but no secondary symptoms. Two weeks before Christmas, 1904, he commenced vomiting, which has continued intermittently ever since, with headache. He complains of frontal headache of variable intensity. Vomiting is occasional, and with a little preceding nausea. Mentally rather dull. No alteration of sensation or movement. No inco-ordination. No localised tenderness. Doubtful flattening of left face. Eyes—normal movements, but marked right optic neuritis. Ears—an old dry perforation in left ear and a large polypus removed from right ear, where there is a slight discharge. A few days ago he had some retraction of the head. The case has rather improved since the removal of the polypus, but the symptoms and physical signs suggest the question of cerebral or cerebellar abscess. As there was no localising symptom he proposed to wait and watch events.

Mr. JAFFREY had found a cerebral abscess on the opposite side to that on which he trephined in two cases, also in a case of cerebral tumour the same thing happened.

Dr. SCOTT thought the headache was not typical in this case. Optic neuritis was certain. There was a possibility of antral mischief being the cause of trouble, and he advised its exploration.

Mr. PERCY PATON showed a man, æt. 55, who noticed a swelling on the right side of his neck nine months ago. This steadily increased in size. The main mass lies under the sterno-mastoid muscle to which it is fixed, and it also has firm deep connections. Its outline is irregularly rounded, its consistency firm. There are several outlying masses similar in nature. One or two can be felt in front of the left sterno-mastoid. The man has lost some flesh and has a good deal of pain. There is no growth to be found in the pharynx,

larynx, or mouth, nor is there any other abnormality. There is no history, nor is there any evidence of syphilis, and the man has had a good deal of potassium iodide without any improvement. He thought there could be no doubt that the masses are malignant and inoperable, and also that the growth is primary in the neck, either being sarcomatous and commencing in the glands or carotid body, or possibly epitheliomatous in connection with the remains of one of the branchial clefts. His impression was that it is an endothelioma beginning in the lymphatic glands or the carotid body.

Mr. LOCKHART MUMMERY remarked on the possibility of the tumour being in connection with the branchial cleft.

Mr. E. PERCY PATON showed the case of a boy, æt. 16, who first came under his care in August, 1903, with the history that for several years he had been troubled with some increased frequency of micturition and pain, which had recently given him greater trouble. On examination he was found to have a large quantity of urine in his bladder which, through a full-sized catheter, he was unable voluntarily to pass, the amount just being under four pints. The bladder wall had practically no contractile power, but no other defect could be found. His urine was a little low in specific gravity, but otherwise normal. He was put under an anæsthetic, but careful examination of the rectum and abdomen revealed nothing, and sounding gave a negative result. He was then treated by tying in a catheter for some weeks, but without doing him any good. It was then thought that possibly the more thorough drainage which could be got by a suprapubic opening might allow the bladder to return to its normal size, and a suprapubic opening was therefore made, and the interior of the bladder as far as it could be reached examined. It seemed in every way normal, except for its great size. A tube was then tied in and the cavity drained for from three to four weeks. The tube was then removed and the opening allowed to heal, which it did very slowly. It remained closed for five months, but has since reopened and leaks a certain amount; the dilatation of the bladder, however, has not been at all relieved, but he is kept very fairly comfortable by the passage of a soft catheter, which he uses twice a day. A careful investigation of his history throws no light on the cause of his trouble. He has had no injury to his back of which he has any knowledge, nor has he at any time so far as he knows ever distended the bladder. His reflexes are normal and no evidence can be obtained of past diphtheria or other disease likely to interfere with the nervous mechanism of the bladder.

Mr. JAFFREY mentioned the case of a boy pushed into a bath; admitted with a large bladder. The urine had to be drained off. It recovered its tone in time.

Mr. PARDOE mentioned three cases bearing somewhat on this. All had inability to empty the bladder. There was a variable flow according to pressure. In the first case a pouch with stones in it was discovered after suprapubic operation. In the second case, a man, æt. about 40, had dilated bladder and a pouch also was found. He advocated in Mr. Paton's case tying in a catheter and allowing to heal. If not, to remove the scar of the wall of the abdomen and of the bladder.

Dr. LEONARD GUTHRIE showed a man, æt. 52, who had for seven or eight years complained of increasing difficulty in walking. The pupils were equal and the reaction normal. There were defective upward movements of both eyes, imperfect convergence and nystagmus on all ocular excursions. The optic discs were excavated, the cribriform plates exposed. Vision was only slightly impaired. His gait was typically cerebellar with a strong tendency to swerve or fall to the left. The knee-jerks were exaggerated. Ankle-clonus absent. Sensation was normal and there were no lightning pains. He had never suffered from headache or vomiting. Speech and hearing were normal, also heart, vessels, and urine. There was no history of syphilis. The condition was probably one of steady progressive degeneration in the neighbourhood of the

Corpora quadrigemina and perhaps of the left cerebellum or its peduncles. It would probably result in paralytic dementia or tabetic general paralysis.

Dr. ALEXANDER MORISON showed a case of *Bilharzia hæmatobia* in a man, æt. about 30, who had been a cavalry soldier in the South African war. Hæmaturia was first noticed after bathing in the Blood River in the Transvaal. The act of urination began by the evacuation of a comparatively clear urine and terminated with the escape of deeply blood-stained urine. The final phase of micturition was painful. Some bleeding in defæcation. From the duration of his symptoms the patient was anæmic and the microscope revealed blood-cells and the ova of *bilharzia hæmatobia*. Treatment was of little avail.

Mr. JAFFREY remarked on the duration of these cases, and Mr. PATON had seen the ova in a tumour of the skin—a rare occurrence.

Mr. PARDOE remarked on the unusual occurrence of complications of this disease in England as compared with Egypt. The cystoscopic appearance of the bladder was interesting in this disease. He made no suggestions as to treatment.

Dr. ALEXANDER MORISON showed a case of Regurgitation through the Aortic Valves, in a man, æt. 49, associated with cardiac pains commencing in the præcordium and radiating into the left arm. The patient had suffered from rheumatic fever when a child, æt. 9, had had small-pox when æt. 22, and had worked hard as a builder's labourer. He was not aware that he had disease of the heart until two years ago, when he began to suffer from cardiac pains. Dr. Morison ascribed the aortic lesion to the early rheumatism, and considered the case of some interest from a prognostic point of view.

Dr. SUTHERLAND doubted whether the aortic lesion dated from childhood. He thought it more probably was to be attributed to atheroma.

Mr. LOCKHART MUMMERY showed a Sigmoidoscope—a modification of Strauss'; it was to be passed in the genupectoral or in the Sims' position. The instrument was 30 c.m. long. The instrument need not touch the bowel-wall on introduction, but should be guided by sight. It could reach to the middle of the sigmoid flexure. It was a useful substitute to exploratory laparotomy where the finger could not reach the site of the disease. [Drawings to illustrate cases diagnosed by its means (papilloma, &c.) were shown.]

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD FEBRUARY 1ST, 1905.

PROFESSOR CHIENE, President, in the Chair.

MR. J. W. DOWDEN read a paper on

RECURRENT TORSION OF THE SPERMATIC CORD.

Torsion of the cord occurred with greater frequency than was generally supposed, but the condition was apt to be overlooked, as it was but scantily referred to in most text-books. Two varieties occurred—(1) A sudden and acute degree of torsion, leading to atrophy of the testicle; (2) more or less frequent recurrence, with or without the eventual onset of an acute degree of twisting. A good deal had been written about the first of these, but not on the second, and this paper, based as it was on five cases of recurrent torsion personally observed, was devoted chiefly to the latter. *Predisposing causes*: The main cause seemed to be a "floating" condition of the testicle (present in all five cases), the testicle, epididymis, and cord being completely surrounded by the visceral tunica vaginalis and hanging free like a fruit on its stalk. Another cause, also found in all the writer's cases, was a broad, flattened arrangement of the cord with separation of its constituents, so that while the vas went to the globus minor the vessels entered the globus major—so-called inter-mesorchial separation of the cord. Either

testicle seems equally liable, and torsion may occur in undescended or descended testicles. Most cases occur at or after puberty, but torsion may take place in infancy, and if so it is almost always incorrectly diagnosed as acute orchitis. Acute torsion often occurs in an undescended testicle. The *exciting causes* of torsion are uncertain. It may come on at night, after strains, coughing, &c., or after crossing one leg over the other. Sudden action of the cremaster muscle has been supposed to produce it. Patients usually came under observation either on account of a more severe attack than usual, or after such an attack had just been passed through, or to avoid the annoyance of repeated recurrence. In these there was a history of sudden sickening, pain in the testicle, a variable amount of collapse, tenderness of the testicle and epididymis, involuntary flexion of the thigh, scrotal swelling developing in a few hours from the onset, and great prostration until relief was obtained. This took place suddenly, the scrotal swelling subsiding twenty-four hours later. These attacks occurred at intervals of weeks or months, sometimes for many years together. On examination during an attack the above points could be made out. Fluid collected in the tunica vaginalis in an hour or two, a tender knot could be felt in the cord, the epididymis might be found to be placed anteriorly, and there was a little rise of temperature. On examination during the intervals the testicle was raised and somewhat horizontal. Rotation round a vertical axis was painful, and the organ was smaller than normal. The *diagnosis* had chiefly to be made from orchitis and hernia. In the former the sudden onset with collapse, the early and intense local symptoms, the knot in the cord, and the altered position of the organ, as well as the absence of urethritis or mumps, were the chief guides. Strangulated hernia was sometimes simulated either by a descended or an undescended testicle in which torsion had occurred. In the former case the pain was followed by swelling (not *vice versa*, as in hernia), the inguinal canal was free. If the testicle were undescended, its absence from the scrotum, along with the presence of a lump in the inguinal canal, preceded by pain, was suggestive. In cases of doubt it was best to operate. In all probability the alleged frequency with which undescended testes became inflamed was really explicable by their liability to torsion. Twisting usually took place from without upwards, and might be through an arc of from 180° to two complete turns. In an acute case venous obstruction resulted; the cord and epididymis became engorged, the testicle doubled its size, and the hernia contained blood-stained fluid. The veins of the cord were flattened, but the artery was pervious. The testicle was completely destroyed by a hæmorrhagic infarct; there was no necrosis, only atrophy. In recurrent cases the repeated attacks of congestion resulted in fibrosis and atrophy. *Prognosis*: The condition is never fatal; attacks will continue to take place and probably there will ultimately be one so severe as to lead to atrophy. *Treatment*: During an attack detorsion should be attempted, the testicle being twisted from within outwards, so as to undo the most common variety of twist; if this caused pain or if there was resistance the reverse direction should be tried. If detorsion failed, operation should be had recourse to at once. In the intervals the treatment consisted in operative fixation of the testicle. The steps were to open the tunica vaginalis, clip away part of the visceral layer, and scrape the testicle, and then suture it below to the dependent part of the scrotum, taking care that there was no twisting of the cord. This operation Mr. Dowden had performed on several occasions, with good results. His first case had been so treated three years ago, and there had been no recurrence.

Mr. DAVID WALLACE congratulated Mr. Dowden on having had so many instances of a comparatively rare malady. He had only seen one case of torsion of the cord in many years.

Mr. MILES described a case of atrophy of the testicle

which followed torsion of the cord caused by falling from a branch of a tree. He thought that the action of the cremaster might readily bring about twisting.

Dr. FLEMING read a paper on

MASSAGE, PASSIVE MOVEMENTS, AND MODIFIED RESISTED EXERCISES IN THE TREATMENT OF ADVANCED CARDIAC DILATATION.

After mentioning the comparatively disappointing results of the Nauheim treatment, the speaker said that during the past few years he had tried the plan of treating cardiac dilatation, with and without valvular defect, by successive periods of massage, followed by passive movement, and then by resisted exercises, with astonishing benefit in cases in which rest and cardiac tonics had failed. Among the various theories promulgated to explain the benefits of such modes of treatment, he mentioned Schott's view that by periodical stimulation the nutrition of the heart muscle is improved, that its contraction becomes more complete, and exercise first raises, then lowers, the blood pressure. Sir Douglas Powell believed that in addition to the general action of massage the heart was stimulated to fuller systole, while Broadbent ascribed the good effects of massage to dilatation of the peripheral vessels and consequent relief to the left ventricle. Lauder Brunton thought that exercises might dilate the splanchnic vessels and thus relieve the right heart. Dr. Fleming believed that massage and exercises braced up the muscle of both sides of the heart; the method was of value as an adjunct to other lines of treatment in many cases of cardiac dilatation, particularly in extreme degrees of that condition. Notwithstanding all that had been said as to the impossibility of accurately gauging the size of the heart by percussion, he also thought that careful observations, taken along with the position of the apex-beat, gave sufficiently definite data, if records were taken from time to time. The method he employed was quite simple. The entire series of exercises prescribed by Schott was not carried out, but they were limited to such movements of the arms and legs as the patient could easily make in bed, and no particular movements were ordered. The duration of the exercises was based on these effects, fatigue never being allowed. When the period of resisted exercise was over, the patient was allowed up, and a few minutes' slow walking was enjoined. Among the cases quoted were the following:—*Case I.*: Female, æt. 47, great dilatation of the heart as compared with previous measurements, the apex-beat being under the seventh rib on the anterior axillary line, and the right border $2\frac{1}{2}$ ins. outside the lateral sternal line. There were systolic, mitral, and tricuspid murmurs, venous engorgement, and irregular pulse. The patient had been confined to bed for six months, and notwithstanding cardiac tonics, she was constantly on the verge of total failure of compensation. After ten days' massage, and a similar period of passive and then resisted exercises, the patient so far improved as to be able to rise on the twenty-first day, and take walking exercise, at first for five minutes, then increasing. The pulse-rate fell to normal, and the irregularity diminished; the apex crept into its old place in the mid-clavicular line under the sixth rib, and the right border contracted to $\frac{1}{2}$ in. to the right of the sternum; in fact, compensation was sufficiently established to allow the patient to take moderate exercise and undertake light work. *Case II.*: Female, æt. 73, with dilatation of the heart and mitral disease. Apex-beat in the seventh space, 8 ins. from midsternum. Dyspnoea, epigastric pulsation, irregular pulse; right border 3 ins. to right of sternum, œdema of lungs, and diminished urine. Very little improvement after seven months' treatment in bed with cardiac tonics. Massage was begun on August 2nd, passive movements on the 9th, and resisted exercises on the 16th. A week later the patient was allowed up for two hours and the exercises were replaced by a short walk. At the same time the size of the heart diminished, and the pulse slowed. Of other eight cases, three were men and five women. Two had aortic and mitral incompetence, and in them the treatment failed; six had mitral and

tricuspid incompetence, and in them it succeeded. Even eight successes out of ten cases seemed to warrant further trial; aortic cases, apparently, were not suitable. As to the permanence of the results: In four cases considerable periods (two years to six months) have elapsed without any failure of compensation; only one case is known to have relapsed.

Dr. G. A. Gelson and Dr. W. Russel discussed the paper.

Dr. GIBSON read a paper on

BRADYCARDIA,

with a lantern demonstration. He considered only true bradycardia, and not that false form in which the slowing of the pulse was due to beats not reaching the periphery. After a brief historical introduction, the nature of the symptom-complex was referred to—slowness of pulse, paroxysmal or permanent, and accompanied in some cases with apoplectiform or epileptiform seizures. The etiology of bradycardia was next considered. Causes were either *exoteric* or *esoteric*, and among the former he named idiosyncrasy (as in cases in which bradycardia was a family affection), nervous factors, toxic agencies, and structural changes in the heart and vessels. Of nervous factors we had such causes as intra-cerebral pressure, cerebral syphilis, meningitis, and tumour of the base of the brain; and, again, reflex causes, such as hepatic or renal lesions, causing paroxysmal bradycardia. Examples of bradycardia from functional nervous causes were to be found in the cases of Colonel Townsend, who had the power of slowing his heart at will, and of fakirs, who are credibly reported to maintain a very infrequent cardiac beat for long periods through vagus inhibition. Among toxic agencies producing bradycardia he enumerated lead poisoning, digitalis, tobacco, and the poisons of diphtheria and typhoid, as well as uræmia and the puerperal state. Most important of all the exoteric causes were structural changes—arterial and cardiac degenerative lesions, and the condition described as hypertonus. The esoteric, or intrinsic, influences producing bradycardia act by interfering with the auricular and ventricular rhythm. In some cases it seems as though the whole heart is slowed; sometimes there seems to be a very feeble ventricular beat which does not reach the periphery, and sometimes the ventricle does not beat at all, though the auricles do. There was no doubt whatever that the auricles gave both audible and tangible evidence of their activity; tracings were shown in which three or four auricular pulsations took place for every one beat of the ventricles. Probably in many cases the conductivity of the auricular impulse was interfered with, and the ventricles did not respond to the stimulus conveyed to them by that band of muscular fibres reaching from the right auricle to the left ventricle, known as Gaskell's bridge. The alterations in cases of bradycardia due to esoteric causes could be analysed under four heads: (1) Modifications of stimulus to the ventricles; (2) modification of productivity of impulse; (3) modifications of excitability; and (4) modifications of conductivity. A number of cardiograms were shown illustrating various alterations in the cardiac rhythm, and the way in which they ought to be interpreted was pointed out. In some cases, where the heart was acting slowly, one or more sounds could be detected between the first and second sound; these were regarded as auricular in origin. They were especially present in cases of senile bradycardia with systolic murmurs. The chief types of the condition were: (1) Permanent bradycardia; (2) permanent bradycardia with syncope or other seizures; and (3) paroxysmal bradycardia with similar attacks. There was often also glycosuria or albuminuria. In his view the Stokes-Adams syndrome was of the nature of an intermittent claudication of the arteries of the base of the brain. The cardiac slowing depended on inhibition; the inhibition was brought about by the apoplectic or epileptic explosion, and this in its turn was due to some change in the vascular current in the brain.

Dr. Mackenzie and Dr. Russell discussed the paper.

LIVERPOOL MEDICAL INSTITUTION.
MEETING HELD FEBRUARY 2ND.

DR. JAMES BARR, the President, in the Chair.

MR. F. T. PAUL exhibited a patient suffering from Popliteal Aneurysmal Varix, which had resulted from a bullet wound.

DR. M. LOEWENTHAL demonstrated a specimen of *Bothriocephalus Latus* and mentioned the treatment he had adopted in the case from which it was obtained.

MR. F. T. PAUL read a note on Enterectomy for Cancer of the Colon. Three recent cases were mentioned, and the portions of the bowel removed were exhibited. Especial attention was directed to the importance and difficulty of making an early diagnosis, many cases of cancer of the cæcum being confounded with appendicitis. As regarding malignancy, these cases gave the best permanent results in the surgical treatment of cancer, and as regarding the dangers of the operation he had not lost a single case, except when intestinal obstruction was present, since he had brought the ends of the bowel outside at the time of the operation. He would very much like to know what the real mortality was after primary end-to-end anastomosis of the large bowel. As a palliative operation he advised short-circuiting whenever it was possible, rather than performing colotomy.

MR. THELWALL THOMAS had taken advantage of the method of operating described by Mr. Paul, in several cases of colectomy, and considered it a valuable advance. Cases being so often seen when marked obstruction had supervened, he had found it impossible to unite the dilated proximal end of the divided gut to the atrophied and collapsed peripheral portion.

DR. E. M. STOCKDALE, MR. P. P. NEWBOLT, DR. J. HILL ABRAHAM, DR. G. C. WALKER, DR. W. BLAIR BELL, DR. W. CARTER, DR. R. HUMPHREYS and the President also took part in the discussion.

MR. T. C. LITLER JONES related a case of Acute Hæmorrhagic Pancreatitis. The patient was a healthy woman, æt. 26, subject to constipation. She was suddenly seized with severe abdominal pain and vomiting forty-six hours before admission to hospital. Laparotomy was performed and there was found to be fat necrosis and about three pints of blood and serum in the peritoneal cavity. This fluid was removed and the pancreas incised in its long axis, with a view to prevent further tissue necrosis due to the action of the ferment. The incision in the pancreas was packed with gauze, which was removed thirty-six hours later. Except for some trouble with the abdominal incision owing to the digestive action of the pancreatic discharge, the patient made an uninterrupted recovery.

DR. W. B. WARRINGTON read a paper on Compression Paraplegia with especial reference to Tumour of the Spinal Cord, and an account of a case of endothelioma removed from the cauda equina. He pointed out that in any case of paraplegia the possibility of compression of the cord was to be considered. Tumours of the spinal cord were about ten times less frequent than cerebral tumours, but about half could be successfully removed, as against 4 per cent. of cases of cerebral tumour. The symptoms were progressive pain, motor paralysis and sensory paralysis. The clinical picture of total block of conduction between the cord and the brain was described, and reference was made to the splanchnic and somatic symptoms in these cases. Cases were then quoted to show that this "block" might be physiological and remediable, calling in selected cases for operative interference. In the case of the patient with a tumour of the cauda equina, there were symptoms of symmetrical affection of the sacral roots—pain, paralysis of the muscles moving the feet, loss of sensation in all the sacral and last lumbar area, disturbance of bladder and rectum and loss of the bulbocavernosus reflex. The tumour which was removed by Mr. R. W. Murray proved to be a malignant endothelioma, and though marked relief occurred for some months, the symptoms then reappeared and the case could only end fatally. The importance of differ-

ential diagnosis between lesions of the last part of the cord (conus medullaris) and the cauda equina was emphasised, as in the latter case the surgeon could often satisfactorily operate. A brief account of the diagnostic features of the different lesions, and their distinction from each other, was given. In many cases of nervous disease the co-operation of physician and surgeon was most desirable.

The President, Professor Sherrington, Mr. Damer Harrison, Dr. Nathan Raw, Mr. R. W. Murray, and Dr. Hill Abram took part in the discussion.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, February 12th, 1905.

EARLY TREATMENT OF CONSUMPTION.

Is it possible to cure consumption? asks Professor Renon. It is possible, and even very probable in the majority of cases, as it has been said that tuberculosis of the lung was the most curable of chronic diseases. This malady can be almost always cured in the incipient stage. Yet there are some, by reason of hereditary taint or some other unfavourable condition, who are not amenable to any treatment, however active.

The therapeutic arsenal for the treatment of pulmonary tuberculosis is well stocked, and even overstocked, remarks Prof. Renon. If we possessed the specific remedy for tuberculosis as we do that of diphtheria, the question would be very simple. Unfortunately, such is not the case. Neither the tuberculin of Koch nor the new tuberculin T.R. have given decisive results. The same may be said of the series of serums recommended by men of good faith and of undeniable scientific standing.

One of the best remedies to be utilised in phthisis is arsenic. It may be given in very small doses:

Arseniate of soda, 1 gr.;
Water, 10 oz.

A tablespoonful twice a day at meals, and continued twenty days a month for three or four months. There are other preparations of arsenic, such as cacodylate of soda and arrhenal. The former is employed by the mouth, the rectum, or subcutaneously. M. Renon prefers the latter mode. He injects one grain dissolved in twenty drops of sterilised water every two days, or eight injections in sixteen days. He then suspends them for eight days and recommences the series. Arrhenal may be employed in the place of cacodylate of soda, but M. Renon thinks it inferior. The *raison d'être* of the arsenical treatment is to keep the patient in good condition and increase his weight if possible, but it should be used with prudence.

Creosote was considered a kind of specific for phthisis for many years, but it frequently aggravates the condition of the patient by fatiguing the stomach, and, on the other hand, it has frequently provoked hæmoptysis. In certain torpid forms of phthisis, however, creosote might be given by the rectum in twenty to thirty drop doses. Synthetic preparations, such as guaiaicol or thiocol, may replace creosote. Thiocol given in 10-grain wafers three times a day has much benefited some patients.

Besides creosote, and acting in a different manner, is urea, utilised first by Harper in England, which has a favourable action in all forms of tuberculosis. It can be employed in subcutaneous injections and by the mouth. Prof. Renon gives it in wafers containing 12 grains each, two to four daily. Tannin is also an excellent preparation, but, unfortunately, this is ill tolerated by the stomach. It has been given in wafers:

Tannin, 5 grs.;
Phosphate of lime, 10 grs.

For one wafer; five daily.

Tannigen is a good substitute in the dose of 4 grains three times a day. The glycerophosphates have a good action on the general nutrition. Two or three 5-grain doses daily before meals. Lately M. Renon has been employing with much benefit a new phosphated

substance called phyline, described by Posternak, which is a phospho-organic principle of vegetal grains. It is well tolerated, improves the appetite, and favours sleep. He gives 10 grains of it before the two principal repasts.

One of the complications of pulmonary consumption is fever. For this rest in bed will frequently be sufficient. Otherwise antithermics must be given. Of these there are a host, but those which have given the best results are aspirin and cryogenin, discovered by Lumière, of Lyons. Either of these agents may be given in four grain doses twice a day, at three o'clock in the afternoon and at six o'clock.

Two other symptoms frequently require attention—hæmoptysis and diarrhoea. The former will be treated by the classical remedies, needless to mention. The diarrhoea is best treated with:

Cotoin, 2 grs.;

For one wafer; two daily. Or—
Methylene blue, 2 grs.;

Lactose, 4 grs.

For one wafer; two daily.

For the cough M. Renon recommends a half-grain of opium two or three times a day.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, February 12th, 1905.

At the Medical Society the discussion on Lesser's paper on the

FINSEN LIGHT TREATMENT OF LUPUS was continued.

Hr. Levy-Dorn said that the violet and ultra-violet rays did not work sufficiently on the deeper structures; they were aided by the heat-rays. Even if the cooling apparatus prevented the warmth being felt, the heat rays still passed through. It could not be doubted that cures actually took place under the treatment. If the treatment did not answer in all cases, it was still very unirritating. Photocautic, which was perhaps too little employed, was an active supporting agent. It was to be wished that the apparatus should be made more perfect and simplified. It appeared as if that introduced from Paris by Marie might be considered an improvement.

Hr. Holländer complained of a something wanting, in that the treatment was not suitable for lupus of the mucous membranes. On the other hand, any particular spot could be reached with hot air. The speaker had obtained the best results when he had thoroughly cauterised first with hot air, and had continued the treatment with the Finsen light, or by placing over the parts a radio-active substance. An advantage of the newer methods over the old was that they acted without actual contact. As regarded cosmetic effect alone, where the lupus was not too extensive the Finsen treatment was most advantageous. The treatment, however, must follow the nature of the case. In any case it was desirable that lupus patients should be treated at special establishments, where all means of treatment were at hand.

Hr. Blaschko observed that chemical agents also acted electively—caustic potash, hydrochloric acid and also the slower acting pyrogallic acid. If any individual lupus nodules remained behind they might heal up as foreign bodies without reaction; in any case extension was slower. In order to destroy such individual nodules the Finsen light treatment was suitable, or perhaps the application of a radio-active substance. Sufficient value had not been placed on tuberculin in the treatment of lupus; he had often employed it with good results.

Hr. Kromeyer disputed the statement that the action of the light was a caustic one. Rather, a serous saturation of the nodules took place after illumination, new connective tissue developed, and the tubercle died. The value of the light treatment and its excellent cosmetic results depended on the fact that the treatment initiated this physiological process.

Hr. Senator mentioned a very extensive lupus treated by tuberculin by himself in 1896; two years ago, when the patient was last seen, there had been no return.

Hr. Guttman pointed out the good results that had been obtained by tuberculin in tuberculosis of the eyes.

Hr. F. Lesser was of opinion that any remnants of disease would be recognised by injection of tuberculin, and believed that the long continuance of treatment and the expense attending it were not sufficiently balanced by the good cosmetic results.

Hr. E. Lesser, after replying to the different objections, said that it was of importance that the treatment should suffer no interruption.

The *Therap. Monatsch.*, December, 1904, contains an article by Dr. H. Ulrici on

THE NIGHT-SWEATS OF TUBERCULOSIS AND THEIR CURE, ESPECIALLY BY VERONAL.

It was most plausible to take Cornet's view as to the cause of night-sweats, that they were to be looked upon as a symptom of the action of tuberculous toxins. Hr. v. Schrötter properly distinguished between sweats in the initial stage and in severe cases. In cases with fever, there was mostly a connection between fall of temperature and the outbreak of perspiration. In contrast to pneumonic cases, in which the outbreak of sweat brings relief, in feverish phthisical patients it caused extreme discomfort and weakened them to complete exhaustion.

Most medical men were in favour of endeavouring to overcome night-sweats. Salter, however, was an exception; he was of opinion that they should not be suppressed as they excreted tuberculous toxins.

The patient should get accustomed to sleep in a cool room, lightly covered, and with open windows; regular and not too warm baths, or luke-warm or cold rubbings night or morning, or both. Salicyl powder, tannofom dustings, and painting with a 50 per cent. formalin solution. Brehma recommended a quarter of a litre of milk, with seven spoonfuls of cognac.

Of internal medicine the antipyretics did not do much. Atropine was in the front rank: it often did good, but it sometimes failed altogether. After atropine came agaricine in the form of a pill. It also relieves cough, but patients got accustomed to it. Camphoric acid also did good and guaiac-camphol, also camphorate of pyramidon. Of other remedies he only mentions veronal, which in reduced doses is a very active remedy for night-sweats. It was given before bedtime, either dry or in tea, in doses of 0.3 grm. The first dose acted scarcely at all, with the second the night-sweat was generally less; after the third it usually ceased altogether. Sometimes one had to wait longer for the effect. In a few cases the dose had to be raised to 0.6 grm.

When the sweats had ceased the medicine was stopped. Sometimes they did not return, and if they did in some weeks' time the veronal was given again. It was often well to continue the medicine for a while in half doses. It only failed in one case, one of high fever, for which pyramidon had been given in the morning. The profuse sweating was scarcely influenced by the veronal.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, February 12th, 1905.

THE CURE OF CANCER.

SEVERAL years ago, it may be remembered, Professor Adamkiewicz caused a great sensation in Austria by publishing his method of curing cancer. For some time this announcement was received by the profession with a considerable amount of scepticism, but Adamkiewicz was strong in his own opinion that he had made a discovery, and convinced others of his power to heal this irresistible morbid condition. Divisions arose in the profession, and challenges were thrown about till Adamkiewicz was offered a ward in the

Allgemeine Krankenhans to prove to the profession that his method of treatment was a success.

The conditions at first were that the neoplasms were to be selected by other professors of the Faculty, and examined from time to time during the treatment, according to arrangement. It is now over ten years since this arrangement was inaugurated, and still he is groping for a cure. During this period, however, he has given to the world different opinions as to the origin and cause of carcinoma, but little hope of a specific. His ten years' experiments may be condensed into a few of his own assertions that cancer cells have nothing to do with epithelium, but are probably parasitic in origin, and in the form of coccidia, as fresh cancerous tissue contains a very characteristic toxin differing in nature from other neoplasms, sarcoma, &c.

He considers this toxin analogous to that found in the dead body, which was probably produced by the parasite and the cause of death. His presumption is that the parasite is killed by this toxin before death ensues, and suggests that the toxin might be used as an antidote. So far he has been unable to isolate the toxin for specific use, but chemically has declared that it is a salt, trimethyl-oxy-ethyl-ammonium-oxyhydrate. According to his own experiments on carcinoma, this toxin has not proved so efficacious as he at first anticipated, but in its use he obtained another derivative which he considers the specific base—trimethyl-vingtammonium-oxyhydrate. This new derivative he terms "cancroin," which may be cited as the theoretical base of Adamkiewicz's method of treating cancer. The hypothesis is somewhat fantastic, and not yet supported by real facts; indeed, it is challenged by general opinion and long since relegated to oblivion that the parasitic origin is not the correct one. His experiment of implanting carcinoma in the brain of animals has not been supported by any other investigators; besides, the hypothesis of a toxin being similar to that found in the dead body and then extracting a derivative is so unscientific that few will hazard an opinion of its correctness.

One proof which he gives is the reaction with this "cancroin," but Albert and Billroth have both left testimony that this is not uncommon in the history of carcinoma. Again other experiments are related where this "cancroin" has checked the progress of the disease, but in this testimony also we have many records to prove that cancer has its intermissions of pause and improvement, as well as local healing in some cases. Virchow affirmed that local cancer often heals spontaneously, while other observers maintain that months and often years elapse without any visible signs of retrogression. This favoured the "Condurango" cure, which was in great demand some time ago. Again, secondary conditions, such as glands and swellings, have often been found to act favourably on carcinoma by setting up inflammation in its surroundings. He gives examples of injecting "cancroin" into subclavicular glands, after which they softened and disappeared. He has other examples in the axilla and mamma, which, he says, kill the cancer cells and eliminate the mortifying matter after having killed the coccidia. He offers another theory for "cancroin," that it acts as a disinfectant, cleansing the tissues and preventing metastasis.

The Operating Theatres.

GREAT NORTHERN HOSPITAL.

CEREBRAL ABSCESS.—MR. PEYTON BEALE operated on a girl, æt. about 25, who had been admitted under the following circumstances:—She was brought to the hospital by the police, who stated that she had fallen off an omnibus when coming down the steps. She was conscious when picked up, and semi-conscious when admitted, but at the same time unable to give any concise account of the fall. There was no paralysis, the face was flushed, and the right pupil dilated; the pulse became slower and the breathing stertorous.

There was a stellate scalp wound on the left parietal region, but on probing this no fracture or injury to the bone could be detected. As the symptoms of cerebral compression were becoming more and more pronounced, she was trephined at the seat of the scalp wound. On raising the bone the dura mater was found to be normal, but there was no visible pulsation. On incising the dura mater, some clear fluid escaped, coming from the frontal region, and some pieces of blood-clot coming from the temporal region. It was assumed that she had a fractured base, and this was apparently verified by the fact that on the next day she had some blood-stained discharge from the nose. The compression symptoms were relieved by the operation, but three days after it they appeared again with increasing severity, so she was trephined again about two inches in front of the seat of the former operation. From beneath the dura mater there was evacuated about two ounces of pus; the cortical brain substance was semi-fluid, and a great deal of it was washed away by irrigation. After this operation she was again relieved, but the right arm was paralysed, and she was unable to speak—that is to say, to express adequately her thoughts and desires. Mr. Beale said that the case was of interest because it was obvious at the second operation that the girl had a cerebral abscess, which was the result of a suppurating frontal sinus; this, of course, accounted for the discharge from the nose, but no previous history of it could be obtained from the patient's friends. Everything, he said, pointed to a fractured skull as a result of the fall, the symptoms of compression being caused by blood-clot, and it was only when the second operation was performed that it was apparent that the fall was the result of giddiness brought on by a commencing cerebral abscess. The improvement after the first operation was, he considered, merely due to the relief of the tension, the latter being brought about by exudation of fluid prior to the formation of pus. The circumstances of the injury were such that there was no eye-witness to state exactly how it was produced. No doubt, he remarked, the unconsciousness at first was simply due to severe concussion; he did not see how under the circumstances the diagnosis of the actual state of affairs could have been arrived at. He pointed out that the paralysis of the arm and loss of speech were probably due to the destruction of cerebral cortex by the accumulating pus on its surface. The small blood-clots which came from the temporal region at the first trephining might possibly, he thought, have been the result of a small fracture in the temporal bone or possibly to slight laceration of the cerebral cortex in this region as a direct result of the fall, but there was no bleeding from the ear, nor could the injury in any way have produced the abscess which was subsequently found.

ST. PETER'S HOSPITAL.

CASE OF PAPILOMA OF THE BLADDER REMOVED BY SUPRAPUBIC CYSTOTOMY.—MR. SWINFORD EDWARDS operated on a man, æt. about 50, who was very obese, and who had had hæmaturia at times over a space of the last six years. For the last month the urine had been always coloured. Cystoscopy a fortnight previously had revealed a papilloma apparently the size of a walnut growing from the left side of the bladder not far from the left ureteral orifice. Before operating, Mr. Edwards performed cystoscopy with a view of confirming the diagnosis; this he was able to do, and he

demonstrated the growth to several surgeons present. Suprapubic cystotomy was then undertaken, the bladder having been previously washed out and distended with about ten ounces of boracic acid solution. Mr. Edwards drew attention to the enormous amount of fat which he had to cut through before reaching the linea alba. The bladder having been opened the finger was passed down to locate the growth, and Thompson's bladder forceps were applied to the pedicle, which was short and about the size of the little finger. Some difficulty was experienced in this owing to the depth of the growth from the surface caused by the fat parietes. Here manipulation was facilitated by irrigating the bladder through the inlying catheter. This floated up the growth between the jaws of the forceps. The growth was partly wrenched and partly twisted off, and came away whole. The finger could discover no pedicle left, but to make sure that it had been taken off flush with the bladder-wall, a caisson tube was passed in and the operative area explored with electric light from a head lamp. By this means the place whence the tumour had been removed was easily seen. A small piece of jagged mucous membrane was cut away, and to the wound was applied a 20-grain to the ounce solution of nitrate of silver. By this time all hæmorrhage had practically ceased and the operation was completed by the insertion of a large suprapubic drain and a further irrigation through the inlying catheter, which was then, of course, removed. Mr. Edwards said that this appeared a very favourable case, and he thought after the complete operation which had taken place a recurrence would be unlikely, though the surgeon must not forget that papillomata in elderly people were liable to become infiltrated at their bases, which was practically the commencement of a carcinomatous condition; indeed, he said, the next patient he was about to operate on, a man, æt. 60, was a case of a like nature, but which had recurred in the space of six months. It had been a much larger growth than the one he had just removed; like it, it was pedunculated, but the pedicle, which was as large round as a man's thumb, was tough and hardish; indeed, it looked at present, he thought, as if carcinomatous infiltration had then already taken place. The great thing to ensure success in these operations, he considered, was first to get the cases early enough; secondly, to be sure, by taking plenty of time over the operation, that all the papillomatous tissue was removed, and this could best be decided by electric illumination through a caisson tube. The risk of this operation, he pointed out, is but slight if free bladder drainage be assured. He proposed to keep the tube in for three days at the outside, and he anticipated that the patient would leave the hospital with the wound soundly healed within the month.

Society of Apothecaries of London.

CANDIDATES competing for the Gillson Scholarship in Pathology are required to send in their names, with testimonials, by February 28th, to the Secretary.

University of Durham.

The Senate of the University of Durham has decided that German may be offered as an alternative subject for Greek in the Preliminary Examination for medical degrees. This concession will come into force in September, 1906.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, FEBRUARY 15, 1905.

THE METROPOLITAN SUNDAY AND KING EDWARD'S HOSPITAL FUNDS AND THE SMALL HOSPITALS.

In concluding the present series of articles we propose offering a short summary of our main points. The omission of a certain number of the small hospitals from the grants of the Sunday and the King Edwards' Funds conveys to the public an unfavourable impression as to the worthiness and good character of the particular institutions thus omitted. Our discussion has been directed mainly to the analysis of facts, which are admittedly not easy in all instances to obtain but we believe that we have in the main secured substantial accuracy as to principles and to broader features. We mention this because Sir Henry Burdett, who came forward to answer some of our earlier strictures in the columns of the *Hospital*, triumphantly exposed some inaccuracies of detail, while he carefully avoided answering vital questions of principle. Latterly, Sir Henry has ceased to offer even these wavering defensive replies, and in default of his championship it would almost appear as if our criticisms were unanswerable. In any case they have been offered with a sincere belief in the past, present, and future sincerity and whole-heartedness of the two Funds mentioned. The interest taken in them by King Edward and by the Prince of Wales guarantees that their policy will sooner or later be reduced to one of absolute justice and fairness. Meanwhile we venture to suggest, on the evidence that we have been offering to our readers during the past six or eight weeks, that there is much room for improvement in the administration of the Funds with regard to the smaller hospitals. We suggest various reforms as worthy of consideration. First, the constitution of the Council of the Funds, which should, in our opinion, be so broadened as to include representatives of all the small hospitals. Second, a clear statement of reasons for not making a grant to any particular hospital. Third, a right of public

appeal against the decision of the Council in refusing an award. Fourth, a clear statement of principles on which grants are made. Fifth, that a public inquiry be made into the sale of the Royal Orthopædic Hospital and the attitude of the Funds in relation thereto. As things go, chaos reigns in the administration of the Funds. Skin hospitals, as we have shown, are tabooed, except in the case of St. John's Hospital, which is a limited liability company, and strictly speaking not a hospital at all. Eye hospitals are all recognised, especially the Royal City Ophthalmic (formerly Moorfields), which, being bankrupt, receives enormous subsidies of the money of the charitable public for some occult reason best known to the Funds. There is no suggestion that eye hospitals should amalgamate, but the policy of amalgamation is enforced to the bitter end in the case of orthopædic hospitals. The chairman of the Royal Orthopædic Hospital, being a prominent official of the Hospital Sunday Fund, is placed in a false position with regard to amalgamation in that particular instance, inasmuch as the sale of the Royal Orthopædic site has brought an enormous sum to the "National." Another prominent official of the Sunday Fund is chairman of a small hospital for fistula, a specialty that is absolutely superfluous and grotesque, but which nevertheless receives substantial yearly awards. Then, again, the fact that *Truth* has for years together mercilessly exposed the undesirable and questionable practices of any particular institution does not prevent the Funds giving them public money in spite of many grave charges unanswered in the law courts. The relentless rigour of the Funds, indeed, seems to be reserved for a few hospitals that are poor and humble, and do not happen to have powerful friends at court. In this respect they share to some extent the position of the poor population for whom this vast wealth of charity is subscribed, but who find themselves to a great extent shouldered out of their birthright by the competition of well-to-do middle-class persons who can perfectly well afford to pay a private medical attendant. The result is that the average general practitioner is forced into a harder and harder struggle to gain a living. In the long run this means an inferior race of medical men available for the service of the nation. There is a great and legitimate field open to the Funds in the regulation of hospital relief. Instead of pouring money for ever into a bottomless pit of indiscriminate alms-giving, let them watch the outgoings, and thereby preserve both the self-respect of the average citizen of moderate means and the welfare of a noble and humane profession. There are enormous material disbursements involved in the administration of the medical charities of the United Kingdom. Contractors, landlords, merchants, lawyers, officials and tradesmen grow rich from being connected with them, whilst philanthropists gain social eminence and titles from the same source: even hospital journalists extract fortunes therefrom. The only persons to suffer

are the general practitioners, who are deprived of an immeasurable amount of legitimate income by the unfair competition of the medical charities. We commend these things to the consideration of the King and the Prince of Wales as matters vital to the future successful constitution and policy of the King Edward's and the Sunday Metropolitan Hospital Funds.

TRYPANOSOMIASIS.

BOTH to the man of science and to the practical student of clinical medicine, the subject of trypanosomiasis is at present one of much interest. Our knowledge of the condition is altogether modern, and has increased so rapidly within the last few years that it is impossible at present to judge to what lengths it may go in the future. The trypanosome is closely allied to the malarial organism in its life history and nature, and the clinical condition to which it gives rise presents many similarities to malaria. This condition, speaking quite generally, as regards both man and the lower animals, includes irregular paroxysms of fever, adenoid enlargements, anæmia, and very often œdema, erythema, and other indications of the presence of toxins in the blood. Up to the present, several different types of trypanosomes have been discovered in relation to different morbid processes. Of these the earliest to be discovered was that which is parasitic in the rat. It is said to be very widely diffused, and to be practically harmless, as no definite pathology has been associated with it. It is believed to be transmitted from animal to animal by the flea. Much more important is the tsetse disease, which has been long known as endemic in parts of Central Africa; its connection with trypanosomal infection, however, has only been recently discovered. Unlike trypanosomiasis of rats, the tsetse disease does not confine itself to one species of animals, but affects all the domestic animals with impartiality—the horse, ass, ox, sheep, goat, and dog. There is no authentic record of the infection of man. There are other diseases of animals occurring in different parts of the world, each due to a different type of trypanosome, as, for instance, *surra*, first noticed in India, *mal de cadava*, endemic in South America, and a widespread disease of cattle in the Transvaal. It is only within the last two or three years that the trypanosome has been discovered in human blood. It had been observed by Dutton, Baker, Manson, and others as occurring in various parts of the tropical regions of Africa, but real importance has only accrued to it by reason of its connection with sleeping sickness. Although Castellani observed the trypanosome in a few cases of sleeping sickness, it is to Bruce that we are indebted for any real knowledge of the facts. It is not to be supposed that sleeping sickness is the immediate result of the presence of the parasite in the blood, for it may be present in the blood for many years without the development of sleeping sickness. It is most probable that the group of symptoms known

under that name only appears when the parasite has established itself in the cerebro-spinal fluid. All the varieties of trypanosomiasis which have been described, with the exception of the disease in rats, probably owe their transmission to some fly of the genus *Glossina*. It is probable that the reason why the disease does not spread outside the tropics is that the necessary vehicle for transmission is not to be found.

SOCIETY FOR PROMOTION OF TRAINING OF NURSES.

A NEW and interesting turn has been given to the affairs of the nursing profession by an application just made to the Board of Trade to incorporate a Society for Promoting the Higher Education and Training of Nurses. Baffled in their attempt to obtain statutory powers for the control of qualified nurses, those who were directing the movement to that end have taken this fresh step with a view to getting together an organisation which will be able, by moral pressure, to accomplish what Parliament practically refused them legal right to do. We think ourselves, and we said so at the time, that the State registration of nurses would, if adequately hedged about with safeguards against abuse, have worked for the good of nurses, patients, and doctors. But the project was not well engineered, and as it made its appearance in two Bills introduced last session, there is no doubt that the bulk of the medical profession was opposed to it, and that opposition was strong enough to scotch it for the time being. The promoters of this legislation were wise to recognise the inevitable, and to decide not to pursue an object which was clearly not to be obtained by a *coup de main*; in face of the hostility of a large section of the medical profession it would have been mere waste of time and money to have brought forward similar Bills this session. They have, therefore, been well advised to desist from their efforts, and to direct their energies to reform of the nursing world from within. Whether the inauguration of the present Society is the best way of accomplishing this it is yet too early to say, but it may be remarked that, as a rule, precipitancy is generally the surest way of delaying a project for which a strong and unanimous demand does not exist among the parties chiefly concerned. The objects of the Society as set forth in their memorandum of association are to promote the higher education and training of nurses, to promote unity of curriculum in the training of persons intended for the nursing profession, to recognise approved nursing schools, to grant certificates of proficiency to persons who pass prescribed examinations, to establish a register of nurses, and to have power to remove names from the same. It is obvious at once that this movement aims at gaining by a flank manœuvre what it failed to win by a frontal assault, for if the Society succeeds in obtaining these powers it will in time practically control the whole course of education and subsequent dis-

cipline of the nursing profession. It is, then, necessary to inquire very carefully into the *personnel* of the promoters and the methods by which they propose to work. Now, we say emphatically that any movement that seeks to emancipate the nursing profession from due subordination to the medical profession is working on radically vicious lines. This is no question of individual liberty, but one of the essence of the efficiency of nursing. However capable, intelligent and accomplished a nurse may be, she cannot act in a plane independently of the medical man; the prime test of her fitness is her power of taking for granted the fact of complete subordination to authority. It is no more possible to free nurses from the control of doctors than it is to free privates in the Army from the control of their officers; one class is trained to command and the other to obey, and no good will ever come of trying to confuse that plain fundamental issue. This being so, we turn to the constitution of the proposed council of management of the projected Society, and we notice that in a council of twelve three seats only are reserved for men, and of these only two are to be necessarily medical men. The remaining nine seats are to be filled by women nurses. In other words, the advice of medical men will be received and listened to, but the control of their own affairs will be entirely in the hands of the women nurses in virtue of their overpowering majority on the council. To our minds this alone vitiates the whole scheme, and unless the constitution be amended to give a complete reversal to these proportions, we can assure the promoters of the Society that they will find no less vigorous opposition from the medical profession than they encountered before the Select Committee last session. For be it remembered that the council of management is not only laying down the curriculum to be followed by nurses, but to prescribe and control the examinations that qualify them for registration, and if it be thought that medical men in their professional capacity will tamely submit to the direction of their subordinates, we can only say that a stupendous lack of the sense of proprieties must animate the framers of the scheme. It is much as if a coachman were compelled to take a couple of horses with him on the box to tell him how he was to drive the remainder of the team. But this proposal is so ridiculous as to be hardly worthy of serious consideration. To persist in it would be absolutely fatal to the whole scheme. Uniformity in curriculum and examination is a worthy object for nurses to seek, and a proportionate representation in the management of their internal affairs a legitimate aspiration; we believe that both these changes—together with the establishment of a register—would be beneficial in the long run to the nursing world. The steps by which they are to be obtained must, however, be clearly approved of by both medical and nursing professions, and agreed upon by their representatives. It will be highly detrimental to the interest of the

nurses if they allow themselves to be rushed or over-persuaded by any one clique or section of advisers. Ourselves, we should counsel them, in their own interest, to act only in conjunction with the medical profession.

Notes on Current Topics.

The Cause of Appendicitis.

At the present moment the public mind is all agog on the subject of appendicitis. Every medical practitioner in the United Kingdom is assailed many times a day with questions as to the cause of the malady. What, indeed? Certainly, in the majority of cases, not grape-stones, nor hurried eating, nor—ye gods!—Hungarian bitter aperient waters. The actual causes are probably complex, inasmuch as inflammation is a symptom that may be set up by a score of different conditions. Broadly speaking, anything that seriously disturbs the intestinal well-being predisposes to appendicitis—that is to say, to the inflammation of a portion of the bowel invaded by one or more harmful kinds of bacteria. In this light it is easy to understand the likelihood of influenza being now and then a cause of appendicitis, as suggested by Mr. A. T. Norton, the well-known surgeon, in our correspondence columns. It is a familiar fact that in some forms of influenza the brunt of the mischief falls upon the gastrointestinal tract. In any case, the theory is worthy of careful attention, even though it add one more to the list of probable causes of a fashionable but disastrous malady.

Mortality in the Profession in America.

OUR contemporary, the *Journal of the American Medical Association*, published lately a series of figures relating to the deaths occurring among practitioners of medicine in the United States and Canada during the year 1904. The figures are not based on precise statistics, but nevertheless present many points of interest. The average age at death among those recorded was over sixty years—not an unpromising outlook—while the average length of practice was over thirty years. Out of about twelve hundred deaths of which the causes were recorded, the disease responsible for the greatest number was heart disease, with 205. Cerebral hæmorrhage caused 179, pneumonia, 172; and nephritis, 91. Tuberculosis has a nearly equal mortality, 90; and of other diseases, cancer, typhoid, septicæmia, diabetes, gastritis, appendicitis, meningitis, bronchitis, insanity, hæmorrhage, peritonitis, asthma, influenza, tabes, paresis, rheumatism, gangrene, erysipelas, diphtheria, and scarlet fever follow in order. The low mortality from infective diseases, apart from tubercle, is very remarkable, considering the exposure to which medical men are subject. The high number of deaths due to pneumonia is, however, very striking. In addition to such natural causes, 143 physicians met violent deaths. Of these 95 deaths were accidental, 36 suicidal, and 12 due to murder. The number of suicides is remarkably

large, and probably much in excess of a corresponding figure in this country. In spite, however, of the dangers surrounding their path, we are glad to see that three physicians passed the age of one hundred.

Typhoid Epidemic at Lincoln.

AN epidemic of typhoid is raging at Lincoln and already has attained dimensions which give cause for grave alarm to the inhabitants of that city. The fever hospital is full and several public halls are being used for the accommodation of poor patients who cannot be properly looked after in their own homes. Fortunately a Local Government Board inspector is on the spot to inquire into the cause of the outbreak and advise, and a temporary medical officer is in charge of the arrangements in the absence of the medical officer of health through illness. It remains to be seen to what extent the epidemic will yet spread, but at the time of writing 345 cases have already been notified. Whatever the final results will be it is obvious that the prosperity of the city must be severely affected, the inhabitants burdened with much expense, and many lose their lives. For this lamentable state of affairs the residents in the cathedral city have only themselves and their elected representatives to thank. There seems to be little or no doubt that the outbreak was caused by pollution of the city water supply, which is derived from the Witham River and is under the control of the Waterworks Committee of the Corporation. Twenty years ago the medical officer of health reported to the Corporation that the Witham was a dangerous source whence to derive the domestic water supply of the town, and seven years ago the Lincoln Medical Society forwarded a resolution to the Council to the same effect. In the letter containing the resolution the Society's secretary (Dr. Carling) pointed out that not only was the water of the Witham open to pollution from many sources, but that it actually received the sewage effluent from the Bracebridge Asylum, in which institution cases of typhoid were then occurring. The clerk to the sanitary authority replied that in the opinion of his committee the word pollution was not one that could be justly used with reference to the Corporation's water, an opinion that was not affected by Dr. Carling's reply that the addition of a sewage effluent to drinking water was generally regarded as pollution. Retribution for their irresponsible folly has waited some time before falling on the heads of the authorities; it is only to be hoped that their obstinacy and ineptitude may serve as a warning to others who decline to take the advice of experts in matters affecting their own speciality.

Honour for a Dublin Physician.

WE learn that Sir Francis Cruise, one of the veterans of Dublin medical practice, has received an unusual honour in that he has been appointed by His Holiness Pope Pius X a Knight of the Order of St. Gregory the Great, and has received

through the hands of Dr. Walsh, Archbishop of Dublin, the Star of that Order. This unwonted honour is the recognition on the part of His Holiness of the life-long study Sir Francis Cruise has devoted to the life and works of Thomas à Kempis. Sir Francis' study of the authorship of the great classic, "The Imitation of Christ," has been translated into most modern languages, and is generally recognised as the most authoritative statement on the subject. It is an interesting fact that the municipality of Kempen, to show their appreciation of Sir Francis' devotion to their great townsman, have called one of their principal streets "Cruise Street." Quite recently, Sir Francis has published an English translation of the great work itself.

Kuropatkin's Illness.

CHARITY hardly covers so many sins as does sickness. Sickness is the only omnivalent excuse for everything—from not going to church to being beaten in a campaign—and very liberally some persons avail themselves of the privilege of pleading it as a pretext. The Sultan achieved an enviable notoriety for breaking down in health whenever it was particularly desirable that he should give a definite answer to representations made to him, and other equally and less distinguished persons have frequently had convenient seizures at uncomfortable junctures. Of Admiral Rojdestvensky we have not yet heard that he suffered from night-blindness or agoraphobia at the time of the Dogger Bank incident, but it would have made a more dignified defence than a plea of torpedo-boat hallucinations. The Pyrrhic victories of his military *confrère*, however, seem to demand an explanation in illness, and surely enough the St. Petersburg correspondent of the *Petit Journal* has risen to the occasion. "General Kuropatkin's return," he telegraphs, "is practically decided upon. He is suffering from cerebral anæmia." For euphemistic periphrases we venture to think that "cerebral anæmia" would be hard to beat. It deserves to rank in happiness of expression with the phrase of a contemporary which described an old lady as "expiring of emotion" on the return of a long-lost son. The brain, we know, like other organs, attains its maximum functional activity in the presence of a rich supply of blood; if that supply be withheld, we presume, it deteriorates. "Cerebral anæmia" thus would account for many strange vagaries and erratic perturbations in the conduct of the sufferer, and might therefore be accepted, we take it, as synonymous with the condition that the irreverent schoolboy would designate in his more homely language as "off his rocker" or "balmy on the crumpet."

Derma Rays.

A PAPER was read and a demonstration given at the Röntgen Society on the 2nd of this month of a new method of treatment of cutaneous diseases by light. The particular rays employed are called the "derma" rays, and they are said to have superseded Röntgen rays to a great extent in America

and on the Continent. It is claimed for these rays that they inflict far less damage on healthy tissues and cause more rapid nutritional changes in unhealthy tissues than X-rays do, and that malignant disease and chronic dermatitis never occur as the result of their action. The derma rays, however, do not seem to be able to give so good a photographic result in the case of injuries to bones. This and much other interesting information, embroidered with the usual reporter's epithets, we glean—not from the pages of a medical contemporary but from those of the *Weekly Dispatch*. We can hardly believe that the readers of this excellent journal are so far ahead of the medical profession in the power of forming a judgment on scientific matters that they should be thought worthy of having these tit-bits of therapeutic information served up for their delectation when the Röntgen Society itself decided to adjourn discussion on the paper presented them till they had had time to read it in print. But perhaps we are too much out of the world to understand the new order of affairs in medical matters—an order which seems to be the converse of what common sense would dictate.

Labour Observed in an Isolated Uterus.

A SERIES of experiments of great physiological and pharmacological importance are reported by Kurdinowsky, who has been studying the uterus of rabbits under varying conditions. He anaesthetised the animals forming the subject of his experiments, and having washed out all blood from the uterus by injecting Locke's fluid into the aorta, removed the organs to a chamber specially prepared and kept moist. The unimpregnated uterus was found to be capable of contracting in response to stimuli for three days after removal, and these contractions followed a definite course which could be recorded by the inscription of a curve. The most interesting of his experiments, however, were those carried out on pregnant uteri, for in these Kurdinowsky was able to follow the process of labour throughout. Contractions were seen to start in the cornua and continue till the fœtus in each cornua was completely separated from the walls, when they were each pushed through the uterine wall at the same moment. Once in the uterus the fœtus is acted on by ring-like contractions of the muscular walls, the Fallopian tube taking an active share in the contraction till the fœtus enters the vagina. Thus it was apparent that the whole act of labour is, or can be, carried out without reference to the central nervous system. Electrical stimulus affected the contractions but little, though chemical and thermic applications were capable of throwing the organ into tetanic spasms. Thus ergot acted well in producing muscular contraction without producing any effect on the vessels; alcohol and chloral, however, did not seem to make much difference. The remarkable feature was the potency of adrenalin, even in high dilutions, in bringing on

uterine action, and the suggestion is that in this drug we have an ecboic of more than ordinary value.

A Valuable Disease.

FORTUNATELY for medical men the majority of sufferers in this world wish to be rid of their diseases and (in many cases) are prepared to pay for means by which this consummation may be attained. An exception is of sufficient rarity to warrant notice. A case of ankylostomiasis was reported last week to the Lancashire County Council, and with commendable promptitude steps were taken to isolate and treat the case before the infection could spread. The Health Committee not having any legal power in the matter, resorted to bribery and offered the man £1 a week if he would remain in the Wigan Hospital for treatment, and later on even larger sums if he would undergo treatment in Manchester. The man, however, was not to be beguiled by filthy lucre to part with so rare a treasure, and his mother declared that if her son was suffering from such a valuable disease he had better keep it. So in this happy England an ignorant miner is allowed to rove freely spreading a noisome and foreign pest among his fellow-countrymen without let or hindrance. There are certain prices to pay for the privilege of wearing the Phrygian cap.

A New Cancer Serum.

WHILE Paris is still busy discussing Doyen's cancer serum, there comes news from America of the discovery of a quite different serum reputed to be a cure for cancer. It is stated that at the Gratwick Pathological Laboratory at Buffalo, as the result of experiments on mice, a serum has been prepared which has a curative effect on cancerous mice. Certain mice are said to have been inoculated with cancer, and, though some of them died, others recovered. It was suggested that the blood of the latter might possess certain antitoxic qualities, and experiment supported the suggestion. The experimenters claim that the injection of serum from the animals that had recovered into the circulation of animals still suffering was followed by arrest of growth of the tumours, or, in less advanced cases, by actual disappearance of the tumours. There is, so far, no report of any experiments on man, so that it is too soon to express any hope as to the result of the investigations at Buffalo. If a cure results, then the ancient proverb of the mountain's travail will have to be reversed. There is, however, another old saying regarding the plans of mice and men which it may be just as well to keep in mind where so baffling a malady as cancer is concerned.

A "Domicilium" or Air Chamber in 1677.

TOWARDS the end of the 17th century, Dr. Nathaniel Henshaw, realising the hardships of foreign travel for the invalid rich, and its impossibilities for the sick poor, sought to solve the difficulties by the construction of a *Domicilium* or Fresh-Air-at-Home apartment. Clearly the air would

not be fresh or pure everywhere, so the modern sanatorium system would not work. Therefore, an air-tight compartment, with door and windows closely fitting, was to be made, and "a very large pair of organ-bellows, the nose of them exactly joyined to a copper pipe must pass through the wall of the room and have a valve opening outward exactly fitted to it, which pipe must likewise have another valve to open inward, one valve at a time being used; . . . working gently with the bellows you may either charge or discharge the air-chamber," regulating the air by means of a weather glass, "and a person may have such air as were not otherwise found but on the Pike of Teneriff, or make it such as is not again to be found upon the face of the whole habitable world." Huge cupping-glasses are also advised to make "powerful revulsions so necessary in some diseases" and a "long sitting-swing, by the use of which the abdominal muscles are gently compressed and the chyle more nimbly protruded from the intestines forward to mingle with the blood." An "able physician," we read, is necessary to judge whether the patient should stay in the *domicilium* during the whole course of acute disease or only spend part of the day there. This little treatise was printed by command of the Royal Society in 1677. In various guises the pure air chamber has cropped up again and again in the treatment of consumption and other diseases. A contrivance of this kind was described in our own columns within the last twelve months.

School Hygiene.

THE increased interest taken by health authorities, and, indeed, by the public generally, is a conspicuous feature in the practical application of science to the things of everyday life. If the recent scare about the physical deterioration of the nation has done nothing more than to awaken school-boards and teachers throughout the land to a sense of their grave responsibility in connection with the health of their scholars, it will have accomplished its mission. The importance of the "gospel of the body" cannot be over-estimated when it is remembered that the building up of the national physique is begun in the class-room. If the cubic space of this be miserably cramped, the atmosphere foul, the ventilation and lighting arrangements inadequate, and physical exercises be conspicuous by their absence, how can young and growing bodies be expected to attain their fullest development? There is a danger, on the other hand, lest practical hygiene be narrowed in its application by too many conflicting theories or by too elaborate details. The recent conference upon the subject held at the University of London in connection with the Royal Sanitary Institute was essentially practical in character, only those questions being discussed which were of really vital interest to school-children as a class and as individuals. The idea that there should be no lessons after school hours in the case of younger scholars, put forward by Dr. Clement Dukes, is excellent,

for surely the tendency to acquire knowledge solely through the aid of books, with the consequent inducement to cramming, is already playing sufficient havoc among delicate and nervous children. The abolition of several of the examinations would also be a step in the right direction. The need for systematic inspection of school-children by medical men was one of the motions formally adopted by the conference.

Water-Drinking in Disease.

THE question as to whether pure water should be allowed in sickness, and if so, in what quantity, may be approached from two entirely different standpoints. In the first place, in many diseases the organs and tissues of the body seem to cry out, almost, for an abundant supply of water, especially when the processes of internal combustion are proceeding at a greater rate than the normal, as in the acute specific fevers. In the case of young children the natural water-seeking tendency is only too often needlessly checked, for, in moderation, it cannot but serve a good purpose. The craving for fluid of some kind in diabetic states is quite another matter, and limitation here is seldom wise. On the other hand, the treatment of diseases by the so-called "water-cure" has reached an extreme pitch in modern times. Aerated or mineral waters, of natural or artificial production, are recommended for the most varied disorders in order to "eliminate toxic materials from the system," while frequent ablutions in divers medicated baths must on no account be omitted if the prescription of the ardent hydro-therapist is to have good effect. Dr. Morris Manges, (a) of New York, considers that the abuse of water-drinking is most often seen in cases of chronic nephritis, and he believes that many a compensated heart is shattered at Carlsbad, or some other popular health resort! The researches of Baruch show that water in small quantities, at the ordinary temperature, has very little effect upon the blood-pressure. It is otherwise when arterial pressure is increased or when arterio-sclerosis prevails. Many authorities have observed nothing but good results from the restriction of fluids in cases of granular kidney. It is of the highest importance to ascertain the condition of the circulation first, before directing the patient to consume large quantities of water, pure or medicated.

Dr. Freyberger as Coroner's General Medical Expert.

THE Westminster Coroner, Mr. Troutbeck, appears to have resolved to place the evidence of his court pathologist, Dr. Freyberger, over that of the whole medical profession in his district, be the case of a general medical or of a purely pathological nature. An illustration of that gratuitously offensive position may be taken from an inquest held last week at Battersea on the body of a woman who died from puerperal septicæmia. Deceased was attended by midwives from a

maternity home under the direction of a lady doctor, whose qualification was stated to be of seven months standing. With the rashness sometimes associated with the newly-fledged diplomate, she appears to have rejected the advice of a consultant to notify the case to the medical officer of health as one of puerperal fever. The lady in question cannot expect much sympathy in her subsequent exposure to "severe censure" in a public court. Now, it will be well to ask the ratepayers and the Town Councils of the districts included within Mr. Coroner Troutbeck's jurisdiction how long this needless waste of public money and this injurious degradation of a humane and liberal profession is to go on in their midst. The evidence of the consultant medical man as to the condition of the deceased, which he diagnosed during life, was clearly enough to establish the cause of death beyond a doubt, in the above case. If necessary, he could have performed the *post-mortem* examination, and there was no more need for the "skilled" services of Dr. Freyberger at a fee of two guineas than there was of an official from the British Museum, or any other superfluous witness. Where is the Lord Chancellor and where the boasted enlightenment and economy of the London County Council?

Kitasato on Bovine Tuberculosis.

ONE of the most interesting contributions to the controversy roused by Koch in 1901 as to the relation between human and bovine tuberculosis is that made by the distinguished Japanese pathologist, Kitasato. His observations are specially important, since the conditions governing possible infection of man by the ox are quite different in Japan from what we are used to in this country. The native Japanese cattle are entirely free from tubercle, and even to experimental inoculation present a remarkable immunity. Imported or mixed breeds, however, show no such freedom from disease. Human tuberculosis, according to Kitasato, is quite as common in Japan as in these countries, and in this he is borne out by the experience of others. Infection by milk can, however, take but a small part in the production of the disease, since even were the cows affected, milk is hardly used at all as a beverage. The average daily consumption of milk in Japan is stated to be only three cubic centimetres—a small teaspoonful—per head. Kitasato's conclusions, therefore, while altogether negative, furnish a strong support to Koch's views, and are at variance with von Behring's doctrine that the starting-point of most tuberculous disease is an intestinal infection, suffered during childhood, from the ingestion of milk.

PERSONAL.

SIR THOMAS MILES, President-elect of the Leinster Branch of the British Medical Association, will deliver the Annual Address at the general meeting of the branch to be held on the 25th inst. at the Royal College of Physicians, Kildare Street.

THE ceremony of presenting the Honorary Fellowship

(a) *New York Medical Journal*, January 21st, 1905.

of the Royal College of Surgeons in Ireland to the Provosts of Trinity College, which was to have taken place on Saturday last, was unavoidably postponed owing to the indisposition of His Excellency, the Earl of Dudley, who was to have honoured the ceremony by his presence.

AN action in which £2,000 damages were claimed was brought during the past week by a farmer against Dr. Patrick Helion Fox, formerly a Major in the Royal Army Medical Corps, for the loss of his arm, occasioned by Dr. Fox firing at him and shooting him. Dr. Fox's evidence went to show that the plaintiff and others had assumed a threatening attitude in consequence of an agrarian dispute, and that he was compelled to fire in self-protection. The plaintiff stated that he had been as quiet on the occasion as he was that day in Court. The jury disagreed, and were discharged.

As a representative of science and higher education, Sir Michael Foster has consented to offer himself for re-election to the next Parliament as member for the University of London. If re-elected he will take his seat as a member of the Liberal party. A committee, with Sir Thomas Barlow as chairman, has been formed to promote his election.

DR. CLIVE RIVIERE, 19 Devonshire Street, W., and Dr. D'Arcy Power, 10A Chandos Street, W., are acting as hon. secretaries for the English branch of the Fifteenth International Medical Congress at Lisbon on April 19th.

SIR JOHN BATTY TUKE will deliver the Presidential Address at the annual general meeting of the Neurological Society of the United Kingdom, to be held at 11 Chandos Street, W., on February 16th, at 8.30 p.m. The subject of the address is the relation of the lunacy laws to the treatment of insanity.

PARIS next May will see her leading doctors gathered at a congress "for the repression of illegal medical practice," which is to be held under the presidency of Professor Brouardel. Maitre Bruno-Dubron, LL.D., will deal with the illegal practice of medicine by ministers of religion, teachers, benevolent associations, and so on.

A MEETING of the Pharmaceutical Society will be held at 17 Bloomsbury Square, W.C., on Tuesday next, when Mr. W. S. Glyn-Jones will open a discussion on a comparison of methods in the United States and in England to secure the purity of foods and drugs. The chair will be taken at 8 p.m., by the President.

THE German Balneological Society will hold its twenty-sixth meeting at Berlin on March 9th; Professor Liebreich will take the chair, and Professors Heuber, Ewald, Eulenberg, and others will read papers.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

SCOTLAND.

The Monson Lectures.—The last of the series of lectures was delivered by Dr. John Macpherson in the Royal College of Physicians on February 3rd. First of all, considering the prognosis, the lecturer said that under the existing system it was not very favourable. Of eleven persons attacked by insanity, four die sooner or later during the attack, while of the six who recover not more than two remain well during the rest of their lives; the other four sustain subsequent attacks during which three of them die. A great deal more might be done, however, to promote recovery from the confusional insanities—the new and acute cases—than is done at present. These, being due to a complication by toxæmia, ought to be treated carefully from the very onset, the destruction of the delicate

cortical cells being so rapid that time was everything. The only way in which our knowledge of these diseases can be advanced is by their study and treatment by hospitalising patients exactly in the same way as if they were suffering from any other acute illness. At present a patient with any acute mental affliction must be certified and sent to an asylum (unless he can be treated at home), without there being any opportunity of examining, observing, and treating him at once in the same way as if he had pneumonia or a broken leg. Framed as they were to safeguard the liberty of the subject, the lunacy laws must in this particular be retained, but we have so far outgrown these laws in this respect, that they no longer secure the patient's liberty, but compel him to be certified before he can obtain relief. In every large city, therefore, hospital wards, and an out-patient department for the care of cases of acute insanity should be opened; these should be open to the public and to students, like any other wards. Such clinics already exist in Germany, Italy, Austria, and Switzerland, and some parts of America; their absence in this country is an instance of passive cruelty which is a blot on our civilisation. The lecturer then took up the need for disencumbering asylums of harmless chronic cases, and treating them in families or on the colony system. Next came the question of the best way of dealing with weak-minded offenders, epileptics, and inebriates. In 1903, 1,300 persons convicted of petty offences in Scotland had upwards of fifty previous convictions against them. This standard was taken as presumptive evidence of mental unsoundness, and Dr. Crawford Dunlop was engaged on the laborious task of examining individually into the mental condition of these frequent offenders. The lecturer gave illustrations of the mental state of these persons, and urged that punishment was useless and reform, in most cases, impossible. The comparative failure of the Inebriates Act was instanced as an example of a mistaken line of reform. In the interests of decency and order, as well as for the welfare of the subjects, inebriates ought to be judicially committed on indeterminate sentences to State institutions, as far as possible under medical management, and not in any way penal. They should be under the lunacy authorities, just as asylums are, the modern asylum of the "village" type being the most suitable institution for their detention, combining, as it does, the advantages of the hospital system and labour colony. He also appealed for the establishment of a national epileptic institution on the lines of the Bielefeld Colony, there being at present no provision in Scotland for the treatment of epileptics except ordinary asylums, which are in too many instances unsuitable for the purpose.

Edinburgh University Honorary Degrees.—Among those on whom the degree of LL.D. is to be conferred at the spring graduation ceremony are William Watson Cheyne, F.R.S., Sir Arthur Conan Doyle, M.D., John Hughlings Jackson, F.R.S., William Keen, M.D., Professor of Surgery, Jefferson Medical College, Philadelphia, and Augustus Walker, M.D., F.R.S.

Glasgow Medico-Chirurgical Society.—An unusually large attendance of members of this Society met in the Faculty Hall, 242 St. Vincent Street, on the evening of Friday, the 3rd inst., when a discussion took place on enteric fever. It was opened by Dr. A. R. Ferguson, on the pathogenesis of the disease, followed by Dr. R. M. Buchanan, City Bacteriologist, on the agglutination test. He preferred to call it by that name, rather than by that of Widal's test, as he thought undue credit had been given to Widal in connection with the serum test, others having a prior claim. In the city laboratory at first the dilution of the blood was one in ten, and the time allowed for the test was half an hour. Experience had now shown, however, that better results were obtained by a dilution of one in fifty, with a time limit of two hours. While some physicians were disposed to minimise the value of the test, he was quite sure it was a very important aid in assisting the medical man in arriving at a correct

diagnosis in many cases of enteric fever, where the other symptoms were not quite pronounced. He asked for complete sympathy between the physician in attendance upon cases of supposed typhoid fever and the bacteriologist in his examination of the blood. Dr. John Brownlee, of Belvidere Hospital, discussed the subject of abortive cases of enteric fever. He mentioned the fact that in the enteric wards of the hospital many of the nurses suffered from attacks of febricula, so in the scarlet fever wards they suffered from sore throats, and again in the measles wards the nurses sometimes were attacked with sore eyes. He urged the need for close attention to the milk supply where there were perhaps several cases in a family, one attacked with diarrhoea and another with a febricula, of two or three days' duration, as such cases in being overlooked were the cause often of enteric spreading not only through a family or tenement, but being more widespread, as the urine may be a means of conveying the infection. Dr. T. K. Dalziel discussed the surgical aspect of enteric fever. He stated that the operation for perforation of the bowel had been performed by himself and his colleague, Dr. MacRae, fifty-seven times in cases of enteric fever. He claimed that he was the first to perform the operation in Glasgow, and he believed he was also the first in Scotland. The perforation was found in the great majority of cases in the small intestine within a comparatively short distance of the ileo-cæcal valve. In only one case was perforation found in the colon. While in Glasgow the number of cases following the operation would not compare favourably with the American statistics, which were placed as high as 40 per cent., it must be remembered that the type of the disease in America was apparently of a much milder character; still the number of cases in the Glasgow hospitals were such as to warrant the operation in all cases of perforation, as then many lives would be saved, where without operation the inevitable result was rapid death. Dr. MacRae discussed the diagnosis of peritonitis in enteric fever, referring more particularly to the symptoms indicating perforation, the fall in temperature and pulse, with a quick rise in pulse, and more especially the facies, which was very characteristic in the great majority of cases, and was quite readily recognised by doctors and nurses alike.

BELFAST.

The Destruction of Rubbish.—Since last week's notes were written more information has come to light about the destructor, to which reference has several times been made in this column. The destructor is question was erected by the Belfast Corporation several years ago at a very considerable cost, though those who had gone into the question of the destruction of rubbish by heat predicted from the first that it could never do anything like what was promised of it. In spite of all efforts by independent members of the Corporation, the details of its working could not be discovered, but were kept a close secret. It was plain, however, to all who saw the resulting ashes being carted away from it that it did no more than toast the rubbish, and though it was said that it developed quite enough heat to destroy all germ life, it was doubtful if it did more than warm it into renewed activity. It has now transpired that there has been no work done by the destructor for some three months, a fact of which even the chairman of the Public Health Committee, Dr. King Kerr, seems to have been ignorant. The serious side of the business is that during all this time small-pox has been prevalent in the city, and all infectious material from houses where cases occurred was supposed to be destroyed at once in the destructor. What became of all this material has not yet transpired, but it is known that other infectious material carted off "to the destructor," as was said, was in reality dumped down on waste ground in the outskirts of the city for rag-men to pick over, and for children to play in! Clearly it is one of those cases where someone ought to be hanged.

ROYAL COLLEGE OF SURGEONS IN ENGLAND.

An ordinary meeting of the Council was held at the Royal College of Surgeons on Thursday, the 9th inst. Mr. John Tweedy, President, in the chair.

The death of Mr. Luther Holden, past President of the College, was reported, and a vote of condolence expressing sympathy with Mrs. Holden, and appreciation of Mr. Holden's services to the College, was adopted.

Diplomas of membership were issued to ninety nine candidates who, having passed the required examinations and conformed to the bye-laws, were admitted members of the College. Nine diplomas in dental surgery, and seventeen diplomas in public health (granted jointly with the Royal College of Physicians) were also issued.

Mr. W. H. A. Jacobson, M.Ch.Oxon, F.R.C.S., surgeon to Guy's Hospital, was re-elected and Mr. Bilton Pollard, M.B.Lond., F.R.C.S., was elected to the Court of Examiners.

Mr. Thomas Bryant, F.R.C.S., was re-elected the representative of the College on the Council of Queen Victoria's Jubilee Institute for Nurses.

The following motion, moved by Mr. Makins, and seconded by Mr. Bowlby, was carried: "That a committee be appointed to consider and report upon the practicability of the institution by the College of a school for the teaching of the early and intermediate subjects of the medical curriculum and of advanced pathology." A committee of eleven members of the Council was thereupon appointed.

Mr. J. Ward Cousins, F.R.C.S., was re-elected to represent the College on the Central Midwives Board.

A letter was read from the President of the Fifteenth International Medical Congress, to be held at Lisbon from April 19th to April 26th, 1906, asking the College to send a representative to the Congress. It was decided to reply that the Council would send a representative of the College.

Correspondence.

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

IS INFLUENZA THE CAUSE OF APPENDICITIS?

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Appendicitis is now becoming a so serious and so constant disease, and is attended with such fatal results, that it behoves the profession to ascertain why this disease should have so recently come upon us, and if there be any means of preventing it. I say "recently come upon us" because, if we look back for, say, five-and-twenty or thirty years, a date before the Listerian method of operating was introduced, we then recognised cases of appendicitis and of pericolicitis—certainly very few in number compared with the present time—though we were cautious in operating on them. I am inclined to think that influenza may be the cause of this terrible increase. I used to point out to my students in the wards that influenza had certain characteristics resembling more of septicaemia, inasmuch as it so frequently resulted in indurations, and abscesses of connective tissue, of glands, &c. In the early times of influenza, cases came under my care of chronic indurations in the neck, with aching pain, and of such stony hardness that even malignant disease could with difficulty be excluded in the diagnosis. These indurations ultimately become absorbed under treatment or suppurated. They were unmistakably sequelæ of influenza.

I have recollections of very numerous cases of influenza followed for months by a septicaemic chart, say, 90° in the morning, and 101° at night, many without objective signs. In every one of these I was able to prognosticate later suppuration, thoracic or abdominal. Among them were cases of pericolicitis and indurations of the abdominal wall, which, of course, were readily diagnosed.

Now, I would suggest to surgeons that they should consider this question, and ascertain whether the numerous cases of appendicitis, &c., now presenting themselves are either immediately or remotely dependent on influenza, and should there be a consensus of opinion that such is the case, then surely influenza should be considered on a par with other infectious diseases, scarlet fever, &c. It should be notifiable, and precaution against its conveyance to others should be compulsory. I look upon influenza as a very terrible disease, the cause of a vast number of deaths altogether apart from the question of whether or not it is the cause of the "appendicitis epidemic." And yet what do we find? Business men in the City telling their clients plainly that they are so ill with the "flue" that they could scarcely come to business, quite careless of the fact that they are at the moment transferring their sufferings—even to death—to their unsuspecting clients. Even some medical men, who are aware of the fact that they have influenza, continue their work as long as their temperature will allow them.

These hotbeds of disease and death do not hesitate, in their ignorance, to use public conveyances; do not hesitate to mix with others or even to go to places of amusement. If it concerned themselves alone, perhaps no one could interfere, but as each case, though itself apparently insignificant, may quite possibly become the cause of death to others, I think it becomes the duty of public health officers to see that in future, so far as law is concerned, influenza shall be put on a par with scarlet fever.

I am, Sir, yours truly,
A. T. NORTON.

Ashampstead.

CAUSES OF APPENDICITIS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Mr. W. V. Black ends his interesting letter with the statement that "appendicitis is a modern affection," but does not give the evidence on which he bases this opinion. If he would kindly do so it would be very valuable. I am old enough to recollect the days before Lister, the days when the idea of operating for appendicitis was practically never entertained. All that could be done was to attempt to palliate the pain. The patients recovered or died as a rule in spite of treatment, perhaps not rarely because of it. In private practice *post-mortem* examinations to verify the exact nature of the malady were never made; the deaths were invariably certified as due to enteritis, or peritonitis, or such-like causes. With regard to hospital practice, I cannot speak so confidently. It would be valuable if the records of some of our great hospitals where the causes of death were most systematically sought for could be examined with a view to elucidating the question Mr. Black's letter suggests.

I am, Sir, your truly,

SENEX.

February 9th, 1905.

PROFESSIONAL ETIQUETTE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—At the top of the second column, page 144, of this week's MEDICAL PRESS AND CIRCULAR (Feb. 8), I read the following words:—"It is needless to say what opinion medical men are likely to hold with regard to a *confre* who attends a patient without the *knowledge and consent* of the patient's own medical man, and almost needless to say that an ordinary Court cannot be made to see the matter in the same light." I have italicised the words "knowledge and consent" for I think that if a patient wishes to have the opinion of another doctor upon his case it is one thing, but that if he must not do so without the "consent" of his own doctor it is another.

If a jury would take one view, and the profession a very different one on such a matter as this, it would be well if the profession and the public came to some understanding upon it.

It seems to me that the liberty of the individual,

and the good of the patient, ought to come before the doctor and his interests in the practice of our profession. The public will lose confidence in and respect for doctors if this great principle is not observed and practised.

I am, Sir, yours truly,

R. L.

Obituary.

DR. ALLEN FENNINGS.

WE regret to announce the death of Dr Allen Fenning at St. Leonards from double pneumonia, after four day's illness, at the age of sixty years. He had resided at St. Leonards for twelve years, and had previously practised for thirty years at Notting Hill. He was formerly house surgeon at Charing Cross Hospital, where he received his medical education. In 1864 he took the diploma of the English College of Surgeons, and in 1866 that of the Edinburgh College, and the degree M.D. of St. Andrews in 1885.

FREDERICK ROBINSON, L.R.C.P., L.R.C.S.I., OF BLACKBURN.

THE death is announced of Dr. Frederick Robinson, the police surgeon of Blackburn, on the 9th inst., after a very brief illness. A native of County Wexford, his father, a Yorkshireman, was lieutenant on board the "Investigator" when that vessel sailed to the Arctic regions in search of Sir John Franklin. Dr. Robinson, who was fifty-seven years of age, had practised in Blackburn nearly twenty-five years, and was appointed police surgeon about three years ago. His loss will be mourned by a large circle of acquaintances and friends.

SURGEON-GENERAL THOMAS WALSH.

WE regret to have to record the death of Surgeon-General Walsh, late of the Army Medical Service, which occurred during the past week at his residence near Dublin. Surgeon-General Walsh joined the Army as an assistant surgeon in 1858. He became surgeon-major in 1875, and brigade-surgeon in 1884. He had considerable experience of active service, as he served in the Afridi Expedition of 1877-78, in the Afghan War of 1879-80, and in the Egyptian War of 1882. In the last campaign he was present at the battles of Tel-el-Mahuta, Kassassin, and Tel-el-Kebir. Surgeon-General Walsh retired in 1898, after forty years' service.

HARRY HARLOCK, L.R.C.P.LOND., M.R.C.S.

THE death is announced of Mr. Harry Harlock, L.R.C.P., M.R.C.S. Eng., who resided for some years near Chichester. He was recovering from an attack of influenza when he contracted pneumonia, to which he succumbed on Monday at the age of 47. The deceased doctor was local medical officer of health and vaccination officer, and an hon. surgeon of Chichester Infirmary. Formerly he resided at Singleton, and prior to coming to Sussex was house-surgeon at Brecon Co. Infirmary, and hon. assistant surgeon at H.M. county and borough prison, Brecknock. The greatest sympathy is felt in the neighbourhood for Mrs. Harlock, who, with her husband, enjoyed the friendship and esteem of a large number of people in the western part of Sussex.

LUTHER HOLDEN, F.R.C.S.

It is with great regret we announce the death of Mr. Luther Holden, at Putney, on February 6th, at the advanced age of 90. He became a member of the College in 1838, and gave instruction to students non-officially in the dissecting room for several years, and soon gained a high reputation as a teacher. Holden was destined to be the last survivor of the candidates who passed the first examination ever held for the diploma of Fellow of the College of Surgeons. In 1846 he became Demonstrator of Anatomy in the Medical School of St. Bartholomew's Hospital, and entered his name as such in the *Medical Directory*. In

1859 he was elected lecturer on descriptive and surgical anatomy conjointly with Skey, but resigned in 1871. His greatest contribution to contemporary medicine was "Human Osteology," remarkable for its beautiful drawings and the then new system of marking muscles attachments. "Medical and Surgical Landmarks," the result of lecture and dissecting-room demonstration, is equally well known. He was a clever and scientific surgeon, though in the beginning having no antiseptic means at his disposal. He was elected a member of Council (F.R.C.S.) in 1863, and served two full terms on that Board, retiring in 1884, and from 1873 to 1883 was a member of the Court of Examiners. In 1881 he delivered the Hunterian Oration. Holden was President of the College in 1879, having held the position of Vice-President during the two immediately previous years. Of splendid physique and excelling in country sports, he was also fond of travelling, and at the advanced age of 83 went to Johannesburg, where he received a warm welcome from the profession. He had no children, but his second wife, well known as a philanthropist, survives him.

CHARLES BATTEN GRACIE, M.R.C.S.ENG.,
L.R.C.P.ED.

THE death took place on the 4th inst., after a brief illness, of Dr. C. Batten Gracie, for over twenty years one of the medical practitioners of Burntisland. Dr. Gracie was a native of Birkenhead, and was in his 49th year, his death being due to heart failure. He was medically educated at Liverpool and at University College, London, whence he took the M.R.C.S.Eng. in 1882, and the L.R.C.P.ED. in the same year. Dr. Gracie was a director of the local golf company at the time the course was extended. He enjoyed the game, and as recently as Wednesday last visited the Golf House Club, when a feeling of faintness proved to be a premonition of the fatal issue.

JOHN STEWART MATHEWS, M.B., C.M.EDIN.,
OF BURNHAM.

WE regret to hear that, on the 5th inst., Dr. John Stewart Mathews, a well-known practitioner of Burnham, was found dead in bed in his residence. The deceased gentleman had recently been treated for an affection of the heart. Dr. Mathews, who graduated in Edinburgh University so long ago as 1868, studied at London, Paris, and Edinburgh.

CHARLES PEGGE, M.R.C.S., L.R.C.P.LOND.

WE regret to note the death of Dr. Charles Pegge on the 3rd inst., at his residence, Briton Ferry. The deceased gentleman, who was about 73 years of age, came to the district a young man in the year 1857. He was a director of the Briton Ferry Works, and for many years chairman and director of the Melyn Timplat Works. He was parish doctor of Briton Ferry, and the medical officer of the local board. His medical education was conducted in Guy's Hospital, London, and he took the M.R.C.S. and L.R.C.P.London qualifications in 1856.

ROBSON ROOSE, M.D.BRUX., F.R.C.P.ED.,
M.R.C.S.ENG.

WE regret to announce the death of Dr. Robson Roose, of Hill Street, London, on the 12th inst., in his 57th year. Dr. Roose entered the medical profession in 1870 as licentiate of the Apothecaries of London, and soon afterwards obtained the licences of the Royal Colleges of Physicians and of Surgeons of Edinburgh. In 1872 he became a member of the Royal College of Surgeons of England, and in 1875 a member of the Royal College of Physicians of Edinburgh, of which he was elected a Fellow in 1877, obtaining in the same year the Doctorate of Medicine of the University of Brussels. He practised for some years at Brighton, afterwards in Hill Street, where he soon obtained a large and fashionable practice.

Literature.

CRITCHLEY'S SANITARY LAW. (a)

THE student of sanitary law has hitherto been compelled to consult various large and bulky volumes in order to obtain the facts about which he wishes to make certain. It is to obviate this difficulty that the present handbook has been prepared. It presents the whole subject in a nutshell. All the important Acts bearing upon a medical officer of health's duties have been carefully summarised, and rendered clearer by the omission of unnecessary legal phraseology. In addition, the present state of the law relating to disinfection, slaughter-houses, and the like is presented in brief. A series of questions taken from various examination papers is appended. We certainly consider that the author has conferred a service in preparing these "aids." Though unpretentious, this small book will be found invaluable as a guide to medical officers of health and others interested in matters relating to public health.

DIAGNOSTIC BACTERIOLOGY. (b)

THIS well-designed and excellently executed manual may well be recommended to busy practitioners desirous of applying the benefits of the best bacteriological researches to the daily needs of clinical work. The title is comprehensive and ambitious, but the author has admirably fulfilled the task he has set himself, and has supplied a really practical work which will prove a trustworthy guide to the clinician. Bacteriological examination of morbid products is nowadays essential to complete diagnosis in many diseases. The practitioner who has not enjoyed the opportunities of studying in a laboratory the progress of modern methods is oftentimes perplexed and confused by the intricacies and complexities of descriptions as given in many works on bacteriology. Dr. Coles knows the needs and understands the difficulties of the practitioner, and has succeeded in meeting the wants of the hard worked but conscientious clinician. The book contains plain, straightforward, and thoroughly trustworthy directions for the spreading, fixing, and staining of films. An important section of the volume is taken up with a valuable study of the acid-fast bacteria and useful deductions for the differentiation of the pseudo-tubercle bacilli are clearly given. The section devoted to a study of the morphological characters of the tubercle and pseudo-tubercle bacilli, and the determination of the degree of their resistance to acids and other agents contains the records of much valuable painstaking research.

The work also contains concise, but sufficiently complete descriptions of the best methods for investigating the organisms met with in gonorrhœa, pneumonia, influenza, diphtheria, plague, actinomycosis, anthrax, relapsing fever, parasitic affections of the skin and hair and other diseases.

There are also useful sections on serum diagnosis and the attractive question of cyto-diagnosis receives attention.

Dr. Coles writes in a thoroughly scientific spirit. He takes a wide and judicious outlook, and has carefully studied the work of reliable investigators. But the work throughout indicates that the writer is no mere compiler but an original thinker, and a thoroughly practical worker. In every portion of the volume there is a personal ring of individual experience which not only attracts but stamps the work as that of a trustworthy and conscientious and scientifically-minded investigator. We commend the work to all practitioners desirous of keeping abreast of bacteriology in its practical applications to the diagnosis of disease.

(a) "Aids to the Study of Sanitary Law." By Harry Critchley, M.A., M.D., D.P.H., &c. Pp. 82. Fcap. 8vo. London: Baillière, Tindall and Cox. 1904. Price 2s. 6d.

(b) "Clinical Diagnostic Bacteriology, including Serum Diagnosis and Cytodiagnosis." By Alfred C. Coles, M.D., D.Sc., F.R.S.E. Pp. 297, with Coloured Plates. London: J. and A. Churchill. 1904.

Medical News.

Cairo School of Medicine.

DR. SYMMERS, who is leaving the service of the Egyptian Government to take up a professorship at Belfast was entertained at dinner by the Cairo School of Medicine. There were present Dr. Ibrahim Hassan Pasha, Dr. H. P. Keatinge, Dr. H. Bitter, Dr. G. Elliot-Smith, Dr. W. H. Wilson, Dr. J. R. Naylor, Dr. A. Looss, Dr. W. A. Schmidt, Dr. F. Milton, Dr. Tribe, Judge Halton, Dr. Fisher, Dr. Beddoe, Dr. Phillips, Dr. Madden, Dr. Nolan, Dr. Shukry Bey, Dr. Innes Bey, Dr. Arloing, Dr. Sandwith, Dr. Symmers, Dr. Harrison, and Dr. Todd. Dr. Symmers was afterwards presented with a fine silver bowl from past and present students.

Anthrax in West Sussex.

A BULLOCK which died on the farm of Mr. John Helyer, of Littlehampton, has been certified to have been affected with anthrax, and has been destroyed by burning. This is the third case of anthrax in the district within the past three weeks, the previous cases occurring at Walberton and Angmering.

Mr. Vanderbilt's Gratitude.

WHEN in Paris recently Mr. and Mrs. W. K. Vanderbilt, the well-known millionaire, both suffered from rheumatism, and were completely cured by Professor Gauthier's light-ray baths. Grateful for his cure, the millionaire sent a cheque for ten times the amount charged, and enclosed a second cheque for £40,000 to complete a dispensary where the poor could have the same treatment free. This hot air cure, Englishmen may be reminded, was invented on this side of the Channel. The original pattern was that of the late Mr. L. A. Tallerman.

International Society of Tuberculosis.

A NEW scientific society has recently been founded in Paris, under the name of Société Internationale de la Tuberculose. Its office is in Paris, where meetings are held monthly, on notice from the general secretary. The scope of this Association is the study of all questions concerning tuberculosis and the centralisation of means of defence. Its work will be regularly published. The association is composed of medical men or scientists holding diplomas from French or foreign universities and colleges. Admission may be obtained by application to the President, which application must be accepted by a committee elected at a general meeting. The annual subscription is 10 francs (os.) For further particulars and for applications address M. le Docteur Georges Petit, General Secretary, 51, Rue du Rocher, Paris, France.

Royal College of Surgeons of England.

THE following candidates, having passed the required examinations and conformed to the by-laws, have been admitted members of the College:—Harry Andreae, Charles Ernest Augustus Armitage, William Arnott, Harold Ramsey Popham Baker, William Girling Ball, Sydney Barradell-Smith, Samuel Landor Benton, Gerald Francis Bird, Arthur Herbert Bond, Robert Henry Bott, Stanley Bott, John Bourdas, William Quinton Bown, Robert Daniel Bridger, Frederick William Broderick, Arthur Williamson Brodribb, Walter Donald Carruthers, William Rex Collingridge, Wilbye Cooper, Robert Hugh Cotton, Harold George Shackelford Courtney, Arthur Douglas Crofts, Leonard Daft, Harold Stewart Dickson, John Harmer Drew, Charles Edward Droop, Lawrence Dukes, Bertram Joseph Eccles, Harry Farncombe, Wilfrid Fawcett, George Edward Ferguson, Charles Henry Fielding, Henry Edward Fox, Francis Gayner, Joseph Sutherland Aikin Graham, Alfred Wallace Harvey, Christopher Patey Harvey, Albert Ernest Henton, James Edward Hoar, Cecil Dacre More Holbrooke, Walter Goldie Howarth, Norman Haliburton Hume, James Aubrey Ireland, Archie Vivian Jubb, Colin King, Frederick Spencer Lister, John

Daniel Stuart Lloyd, Otto William Axel Lowe, Ernest McIntyre, Harold Charles Mamlock, Alexander Manuel, Herbert Frank Marshall, Aurelius Victor Maybury, Charles William Moore, Conwy Llewellyn Morgan, Arnold Morris, Jonas Morris, Leonard Newsom Morris Joseph Archie Mulvany, Alexander Murdock, Edgar Coningsby Myatt, William Steward Nealor, William Henry Newton, Jeffrey Alexander Amherst Orlebar, William Erasmus Paramore, Herbert Wilberforce Perkins, Bernard Pickering, Stephen Hugh Pitcairn, John Edward Pratt, Reginald Puttock, Frank Douglas Roberts, George William Ross, Leslie Martin Rosten, Francis John Russell, William Mackenzie Sadler, Julius Benedict Simpson, Eric MacLeod Smith, Evelyn Charles Sprawson, Ambrose Thomas Stanton, Harold Foster Strickland, James Herbert Sutcliffe, Leonard Smith Talbot, Gordon Wilson Thomas, Isaac Thompson, James Aubrey Torrens, Sydney Booth Turner, William George Turner, Frederick Graham Twigg, Fred Newton Walsh, Albert James Walton, Horace Walshman Ward, Stanley Herbert Warren, Stanley Martin Wells, George Trench Western, Samuel Henry Westman, Francis Henry Whitehead, Alfred James Wigmore, Eric Maurice Wilkins, Percy Charles Woollett.

Royal College of Physicians of Edinburgh, Royal College of Surgeons of Edinburgh, and Faculty of Physicians and Surgeons of Glasgow.

THE quarterly examinations of the above Board, held in Edinburgh, were concluded on the 28th ult., with the following results:—

Final Examination.—Of 75 candidates entered the following 34 passed the examination and were admitted L.R.C.P.E., L.R.C.S.E., and L.F.P. and S.G.:—Alexander Robb MacIntyre MacIlraith, Joseph Millar Gordon Ewing, William MacLaren MacIlraith, John Roberts, Arthur Gilbert Michelsen Middleton, John George McLeod, Alfred Lionel Johnston, James Archer Brown, Isaac David, John Hay Heddle, Frederick Nassau Hughes, Peter John Fisher Houston, Mary Brice Carr, George Christopher Grundy, Martin Arnold Gibbs, George Abeyesinhe, Anna Mary Mulholland, Sorab Kaikhoshru Engineer, Nuno Joseph Rodrigues, John Joseph Lawton, David Smith, Nicholas David Sweetnam, James Samuel Nelson, John Lawrence Power, Albert Davies Edwards, John Forbes Webster, Robert Whitson Telford, Edward Tambyah MacIntyre, Ernest Howard Edward Coghlan, Francis Baillie, Dhanjibhai Fardunji Mullan-Feroze, William Frank Hague Ives, Edgar Arthur King, and Waradana Aralis de Silva, and 5 passed in Medicine and therapeutics, 2 in surgery and surgical anatomy, 5 in midwifery, and 5 in Medical Jurisprudence.

Royal Army Medical Corps.

THE undermentioned gentlemen were successful at the recent examination in London for Commissions in the Royal Army Medical Corps (68 candidates):—Charles Pinkerton Thomson, M.D.Glas., George Wykeham Heron, M.R.C.S.Eng., L.R.C.P., Robert John Bertram Buchanan, L.R.C.P. and S.I., George Brooke Forbes Churchill, M.R.C.S.Eng., L.R.C.P., William Steward Nealor, M.R.C.S.Eng., L.R.C.P., James Edward Hoar, M.R.C.S.Eng., L.R.C.P., Richard Graves Meredith, L.A.H.Dub., M.B. R.U.I., Frederick Emilius Roberts, M.R.C.S.Eng., L.R.C.P., George Smith Wallace, M.B., Glas., Wilfred Parsons, M.R.C.S.Eng., L.R.C.P., Arthur Anderson McNeight, M.B.Dub., Ernest Brabazon Booth, M.D.Dub., Thomas Holroyd Gibbon, M.D.Dub., Richard James Campbell Thompson, M.R.C.S.Eng., L.R.C.P., Ernest George Robert Lithgow, M.R.C.S.Eng., L.R.C.P., Pierce Power, M.B., R.U.I., Charles William O'Brien, M.R.C.S.Eng., L.R.C.P., Ryder Percival Nash, L.R.C.P. and S.Edin., James Sydney Pascoe, M.R.C.S.Eng., L.R.C.P., Cecil Dacre More Holbrooke, M.R.C.S.Eng., L.R.C.P., John Maurice Bisdie Rahilly, M.B., B.S., George Grant Tabuteau, L.R.C.P. and S.I., Richard Edmond Humphrey, L.R.C.P. and S.I., William George Maydon, M.B.Aber., Garfield Ormrod, M.B. Edin.

Notices to Correspondents, Short Letters, &c.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initial*, and 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 re-forwarding 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.

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.

G. H. B.—Things as you say have not changed for the betterment of the profession, but we are afraid its members have themselves to thank in great measure for the trend of events. We never had a doubt as to the ultimate result if the measure became law, and worked long and hard to stir up the profession with regard to it, but the usual apathy prevailed and before the present year has run its course, a still more serious state of things will, we fear, be experienced.

A VACANCY.

AN American Christian Scientist lately had under her care a lady who was taking a course of "absent" treatment. The course was interrupted by the patient absenting herself from this terrestrial globe—a fact not communicated to the "healer." The bill for fees came in in good course, when the husband to his surprise found he had been charged for two weeks after his wife's death. His indignant protest was calmly met by the fair scientist with the response, "Oh! I thought I noticed a vacancy about that time."

DR. MOSS will find the treatment pursued in the Paris Hospitals in a similar case in our issue for January 18th, under the heading of "Paris Clinical Lectures."

INSURANCE.—A company has a right of terminating a policy whenever they please, nor are they under any obligations to justify their action.

J. D. R.—The series you refer to is "English Men of Science," and edited by Dr. T. Reynolds Green.

DR. W.—Echinococcus infection is such an infinitesimal risk, that preventive measures possess at most a technical scientific interest or value.

ABSTAIN.—You would find all you want in Dr. Valpy French's "Nineteen Centuries of Drink in England."

MR. H. WILSON.—We fear the advice given in the publication referred to is not always disinterested. Itinerant Guides are necessarily biased, and the most reliable information is the experience of friends who have actually resided there. From personal knowledge we should certainly not recommend Biarritz as a winter resort for any but the most energetic. In the early spring on the other hand, the climatic conditions are most delightful. Algiers, the Riviera, or Egypt, would be much more suitable for the case you speak of.

LEX.—Under Sec. 21 of the Coroner's Act 1887, the coroner is empowered to summon the medical man, if any, who attended the deceased in his last illness and "may direct such medical witness to make a post-mortem examination."

J. L. S.—Some cases of carnophobia have been known, one in which a young soldier showed an absolute repugnance to meat and complained of general urticaria and weakness after partaking of that kind of food.

UNREGISTERED.—The mistake arose because you confounded the *Medical Register* with the *Medical Directory*. Anyone who is doubtful whether his address is in the former or incorrect should write at once to the office. A post-card is always sent in answer.

D. P. H.—An occupation rash is to be suspected when it begins on the hands and forearms. In such cases no routine diagnosis of eczema should be accepted as satisfactory.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, FEBRUARY 15th.

ROYAL MICROSCOPICAL SOCIETY (20 HANOVER SQUARE, W.)—8 p.m. Paper:—Mr. J. E. Stead: Practical Micro-Metallography with Experimental Demonstration.

ROYAL METEOROLOGICAL SOCIETY (70 VICTORIA STREET, WESTMINSTER, S.W.)—7.30 p.m. Papers:—Mr. E. Mawley: Report on the Phenological Observations for 1904.—Dr. H. Elias and Mr. J. H. Field: Observations made during a Balloon Ascent at Berlin, Sept. 1st, 1904.—Mr. J. R. Sutton: The Winds of East London, Cape Colony.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 CHANCERY STREET, W.C.)—4 p.m. Mr. E. Owen: Clinique. (Surgical.) 5.15 p.m. Dr. G. H. Savage: The After-Effects of an Attack of Mental Disease. **CENTRAL LONDON THROAT AND EAR HOSPITAL** (Gray's Inn Road, W.C.)—5 p.m. Demonstration.—Dr. D. Grant: Larynx.

THURSDAY, FEBRUARY 16th.

CHILDHOOD SOCIETY AND THE BRITISH CHILD-STUDY ASSOCIATION (Parkes Museum, Margaret Street, W.)—8 p.m. Discussion on the

Proposed Anthropometric Survey (opened by Mr. E. W. Braubrook, Dr. J. Gray, Prof. H. B. Kenwood, and Dr. F. Warner). (Arranged by the Childhood Society.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 CHANCERY STREET, W.C.)—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Mr. E. Clarke: Ocular Headache: Its Causes, Diagnosis, and Treatment.

MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST (7 Fitzroy Square, W.)—5 p.m. Lecture: Dr. G. Johnston: Demonstration of Selected Cases. (Post Graduate Course.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.)—4.30 p.m. Dr. A. J. Whiting: Electro-Diagnosis.

FRIDAY, FEBRUARY 17th.

EPIDEMIOLOGICAL SOCIETY OF LONDON (11 Chandos Street, Cavendish Square, W.)—8.30 p.m. Paper: Prof. E. J. McWeeney: The Pre-tosa in Relation to Disease (illustrated by specimens and slides).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 CHANCERY STREET, W.C.)—4 p.m. Mr. A. Lawson: Clinique. (Eye.)

TUESDAY, FEBRUARY 21st.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.)—4.30 p.m. Dr. G. N. Meachen: Seborrhoea and Seborrhoeic Dermatitis.

Vacancies.

Royal London Ophthalmic Hospital (Moorfields Eye Hospital), City Road, E.C.—Curator and Librarian. Salary £120 a year. Applications to Robert J. Bland, Secretary.

St. Helens.—Surgeon to the Works Sick Club. Salary £200 per annum, with furnished residence, light, heating, and attendance, sine board. Applications to F. B., Box 36, Post Office, St. Helens.

Brompton Hospital for Consumption and Diseases of the Chest.—Assistant Resident Medical Officer. Salary £100 per annum, with board and residence. Applications to the Secretary.

Egyptian Government—Ministry of Public Instruction.—Professor of Pathology and Bacteriology at the School of Medicine, Cairo. Salary £200 per annum. Applications to the Director, Government School of Medicine, Cairo, Egypt.

Eastern Counties' Asylum for Idiots, Imbeciles, and the Feeble-Minded, Colchester.—Resident Medical Attendant. Salary £25 per annum, with furnished apartments in the Asylum, board, and washing. Applications to John J. C. Turner, Secretary.

Corporation of Manchester.—Monsal 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.

Birkenhead and Wirral Children's Hospital, Woodchurch Road, Birkenhead.—Male House Surgeon. Salary £100 per annum, with board, residence, and laundry. Applications to F. W. Archer, 5 Storeton Road, Birkenhead.

Hartlepool Hospital.—House Surgeon. Salary £100 per annum, with board, washing, and lodging in the institution. Applications to Robert M. Edgar, Assistant Secretary, 5, Catherine Street, Hartlepool.

Royal Buckinghamshire Hospital, Aylesbury.—House Surgeon. Salary £100 per annum, with board, and furnished apartments. Applications to Geo. Fell, Secretary, Rickford's Hill, Aylesbury.

Bethnal Green Infirmary.—Assistant Medical Officer. Salary £100 per annum. Applications to the Medical Superintendent of the Infirmary, Cambridge Road, N.E.

Appointments.

BURNETT, ARTHUR H., M.R.C.S. Eng., L.R.C.P. Lond., House Surgeon to the Rochdale Infirmary.

CROSLAND, G. W. KILNER, M.R.C.S., L.R.C.P. Lond., Honorary Surgeon to the Huddersfield Infirmary.

PEARSON, J. SIDNEY, M.A. Cantab., M.R.C.S., L.R.C.P. Lond., Officer and House Surgeon to the Victoria Hospital for Children, Chelsea.

ROWELL, J. GEORGE, M.R.C.S., L.R.C.P. Lond., Honorary Surgeon to the Huddersfield Infirmary.

SCOTT, GRAHAM, M.R.C.S., L.R.C.P. Lond., Junior Anaesthetist to the Central London Throat and Ear Hospital.

Births.

SASS.—On February 12th, at 75 Holland Park Avenue, W., the wife of Wilfred Sass, M.R.C.S., L.R.C.P. Lond., of a son.

TRAILL-THOMPSON.—On February 7th, at Claverack, Wembley, Middlesex, the wife of Dr. W. D. Traill-Thompson, of a daughter.

Marriages.

PATERSON—HOLMAN.—On February 11th, at the Parish Church, Budleigh Salterton, John Yates Paterson, of Finchley, Middlesex, and 8, Breams Buildings, Chancery Lane, London, to Bessie Penelope Camplin Holman, eldest daughter of the late Charles Henry Holman, M.R.C.S., of Niton, Isle of Wight.

Deaths.

FENNINGS.—On February 9th, at 1 Pevensey Road, St. Leonards-on-Sea, Allen Fennings, M.D., M.R.C.S., L.R.C.P., I.S.A.

BOOSE.—On February 12th, F. C. Robson Boose, M.D., LL.D., F.R.C.P. Edin., of Hill Street, Berkeley Square, in his 57th year.

EVLIN, BERESFORD.—On February 13th, after a long and painful illness, Sarah Louisa, the dearly-beloved wife of Beresford Evlyn, M.D., Wimpole Street.

PLAISTER.—On February 11th, at Pembury House, Tottenham, Alice Emma, the dearly-beloved wife of W. H. Plaister, M.R.C.S., aged 55.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

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WEDNESDAY, FEBRUARY 22, 1905.

No. 8.

Original Communications.

Inaugural Address ON THE

RISE AND PROGRESS OF GYNÆCOLOGY. (a)

By WILLIAM ALEXANDER, M.D., F.R.C.S.,
Honorary Surgeon, Royal Southern Hospital, Liverpool;
President of the British Gynæcological Society.

I PROPOSE to bring before you to-night my own experience of the rise and progress of gynæcology. When I was a student of medicine, there was no gynæcology worthy of the name. It is true that McDowell had performed several ovariectomies early in the century, and that Wells, Keith, and others, at the time of which I am speaking, were engaged in placing abdominal operations upon a sound foundation. Even the foremost of the profession in the cities and towns of Britain outside the capitals only opened the abdomen occasionally, and with discouraging results.

During my pupilage, we had medicine, surgery and midwifery. The abdomen belonged to the physician, and "inflammation" was a name of dread, and included many diseases now treated successfully by the surgeon or gynæcologist. Abdominal tumours were, in my early hospital days, referred in the first instance to the physician, and it was only on the failure of medical means, which sometimes included tapping, that the case was handed over to the operator. The delays caused in this way were often detrimental to the prospects of the case, and it required a severe contest to obtain an alteration of the rule, so that abdominal tumours might be sent direct to the surgeon or gynæcologist.

Whilst the physician treated all the internal diseases of the abdomen, the obstetrician did the necessary repairs after parturition, such as perineorrhaphy, the woman naturally consulting the obstetrician who attended her during her confinement for any trouble with the reproductive organs.

The obstetricians, with their small experience in operative work, were very often indifferent surgeons, and in their uncertain command of time did not always care to have the anxiety and worry that accompany the arrangements for, and the trouble connected with, an operation.

In my young days there were general surgeons who practised the few operations on women then common, but most of their time was devoted to general surgery. To these, the obstetricians handed over their cases, and these were the representatives of the gynæcologists of the present day, but with too much of the surgical art in their composition and too little of the other arts that make up true gynæcologists.

When gynæcology embarked upon an independent course, she started with certain gifts as "send-offs" from her three elder sisters. Medicine gave her the knowledge that the reproductive organs were part and

parcel of the whole economy. These organs when diseased mutually acted and reacted upon all the other organs, and this relation requires to be kept in view by the gynæcologist, if he would avoid the commission of serious errors.

From the obstetrician, gynæcology obtained a knowledge of the changes produced by pregnancy on the reproductive organs and of the damage that parturition causes or leaves in its train. The obstetrician and the gynæcologist work in the same field, and such near relatives should naturally be also firm friends.

To surgery, however, gynæcology is most indebted. The great successes of the past half-century have been on the surgical side of gynæcology. It may be said that gynæcology and surgery have flourished side by side, one branch now teaching, and now being taught by, the other, and both assisting in the great advance that has taken place in all surgical procedures. Surgery and gynæcology have domains that are adjacent or that sometimes overlap, and work on the boundary requires a knowledge of both specialties. For example, a diseased ovary may be complicated with an adherent appendix, and the latter has to be removed by a surgical operation. The bladder or intestines may be injured in operation on the uterus, and the repair must be done by the operator. Both work in the abdomen, and both require to have a common knowledge of how to work safely there.

This common knowledge is of such great value that some men who possess it in a high degree take up the rôle of abdominal surgeons. Some of your former Presidents were as much at home in operating on the gall-bladder as on the uterus; on an appendix vermiformis as upon the uterine appendages. Many of the Fellows are not pure gynæcological specialists, but are able to deal with any surgical complication they may meet with in their usual work. This is a good feature, and gives broader views, improves the practice, and allows men to attach themselves to gynæcology whose minds are enriched with experience in cognate studies. This is different from the narrow groove in which candidates for other specialties have to travel. Their field is much restricted, and whilst waiting for practice, the candidate must not even look over the hedge into neighbouring fields, and should he allow it to be known that he knows anything about other medical or surgical subjects, the purity of his specialism will be dimmed and his prospects impaired. This method of natural selection of specialists in gynæcology, whilst allowing more freedom, brings to their society men of wider and of larger experience. The nature of the work requires such men, as the conditions to be met with on opening the abdomen may be so complicated and varied that although the primary operation is gynæcological, the complications may require the highest surgical experience.

In my early days the representatives of the present class of gynæcologists were very different men to what they are now. They were not surgeons, but were experts in applying pessaries and fixing the womb by such supports to the exact position that they considered normal. Erosions of the cervix, endometritis,

(a) Read at a meeting of the British Gynæcological Society on February 9th, 1905.

and polypi uteri were their staple diseases. Many of these men were leaders of their age, but the sole monuments we possess of many now are pessaries which are known by their several names. Now, although we do not consider the harmless art of pessary inventing to be a crime, it would be difficult at the present day to build a reputation upon it. While we may not do so much harm by the universal application of pessaries as our forefathers may have done, we certainly cannot use them with the same skill, and we should take care that a knowledge of their use does not die out in the younger generations. The removal of uterine polypi was a favourite operation, and remembering as I do the numerous operations of the kind then performed, I wonder what blight has destroyed the crop of these tumours. In fact, after I commenced practice, it was quite unusual for a gynaecological case to consult me who, according to her statement, had not had a polypus removed at some previous time. Touching up erosions and passing medicaments into the uterus for endometritis were common events. The passage of a uterine sound was a routine proceeding, and no doubt often produced inconvenient or even deplorable results. The use of the sound and the speculum were then novelties, and no examination was held to be complete where both instruments were not used. Now the *tactus eruditus* takes the place of both, and the instruments are used rarely and only for specific purposes.

One of the most serious operations of that time was repair of the perineum, and I remember one case which shows the contrast between the practice then and now in perineorrhaphy. The surgeon took some time to take thin parings off the edges of the cleft, which bled profusely, and ice-cold water on compresses was applied to check the bleeding. Silk or silver wire sutures were used, and several attempts were generally necessary to secure a fair result. The operation lasted three hours, the patient being, of course, much blanched at the end. In a report of that time which I remember, two out of twelve cases died after operation, and only one of the twelve was found to be successful twelve months afterwards. Now, thanks to the advances made by Tait and others, the repair of a perineum does not take many more minutes than it then took hours, and a death from the operation is a most exceptional event. I have not heard of any for many years. The operations are now generally a success from a surgical point of view at the first attempt, and the object of the operation is more often attained for a much longer period of time. Abdominal operations were not much performed, and when they were they were mostly fatal. Spencer Wells had at that time commenced to compile his thousand cases of ovariectomy, with a gradually decreasing mortality, reaching, in 1869, 145 cases with a mortality of 37, or 25.6 per cent.

If I describe a picture of my student days, we will be able to see at a glance why abdominal surgery was not a success then. Take a scene which is vividly impressed upon my mind and occurred in 1868. The operating surgeon comes into the theatre faultlessly dressed, linen irremovable, and nails without the slightest trace of mourning, a spotless, well-groomed gentleman. He takes off his coat, rolls up his sleeves, retires to a passage that runs behind the theatre, whence he emerges attired in an old dusty coat, bespattered with the blood or pus of a long series of former operations. He pulls the collar up about his ears and the flaps of the breast of the coat across his chest. The sleeves are folded at the wrists. He then picks up the silk intended for the ligatures and a piece of cobbler's wax, and while he is waxing the threads he gives a clinical lecture on the case about to be operated on. When each silk thread is waxed sufficiently, he hangs it over the ledge of the theatre, where it remains until ready for use. The assistants wear old coats or jackets or their ordinary clothes, their hands are washed if dirty, not specially as a matter of routine. The instruments are taken out of baize-lined cases as they are wanted, and appear to us to be bril-

liantly clean. The operation table, a wooden structure with movable parts, sits in a narrow area surrounded by the theatre seats, where 100 students, many of them fresh from the dissecting-room, are craning over, and their effluvia pervades the atmosphere over the wound. But worse remains. The operation-table sits on a trap-door in the floor. An opening in the floor is closed, but is not hermetically sealed, by the trap-door. This opening leads to the mortuary beneath, and is it any wonder that a few days after operation we oftentimes saw the dead body of a previous operation case hauled up and the disease from which he died demonstrated to us by the same surgeon who had performed the operation? In tones of deep sorrow he would describe the sad history of the case, and the inexplicable blood poisoning that had marred what for a day or so promised to be such a brilliant success. We wonder how any operation cases survived under such circumstances, but many did, and about one in four or five was the usual death-rate in amputations at that time. I remember an amputation of the thigh healing by first intention. The surgery was excellent, and some operators had instinctive ideas of surgical cleanliness, and obtained successes without being able to give a reason, much less to teach the elements of their successes to others. They were supposed to be "lucky beggars," and were much envied by their fellows. They had no guide to point out the right ways and the wrong until Lister came and enunciated the germ theory of disease. This was Lister's great discovery. The use of carbolic acid as a dressing was a detail, and only the first method of applying the principles of the germ theory to treatment. The diffusion of such a germicide as carbolic acid into the atmosphere of operation-rooms, such as I have described, and over the hands of the surgeons and over the skin of the patients, worked wonders upon the results of general surgery. Old coats disappeared, *post-mortem* rooms were banished to the outside, surgeons ceased to be pathologists, and dissecting students were dealt with so that they ceased to be a menace to operators. In abdominal surgery the results were no less striking with many operators. The uniform fatalities of many places were now varied by successes, although the spray and the use of strong lotions did harm when applied to the peritoneum too profusely.

In 1877, when Lister came to London, Sir Spencer Wells had his mortality reduced from 25.5 to 9 per cent. Wells was a born ovariologist. He had no more enlightenment than his contemporaries upon the real causes of blood poisoning, and knew nothing of the germ theory or of antiseptics till he had placed ovariectomy on a sound basis; but he had unconscious instincts that led him to choose the right way through the fogs in which he had to live and work. Listen to the following quotation from Sir Spencer Wells' book, entitled "Ovarian and Uterine Tumours," 1882:—

At page 218, he writes:—"Long before Lister had tried any of his methods, I had insisted upon all possible care in protecting patients before, during, and after operation, from all known causes of excessive mortality, and I took unusual precautions against any risk of contagious or infective disease being communicated from without, or the development from within of anything that could set up traumatic fever or blood poisoning. I contended that obstetrics and operative gynaecology should seldom be permitted in the same surgeon in private practice, and that such an operation as ovariectomy should never be performed where patients with uterine cancer or offensive discharges of any kind may pollute the place; and cleansing or purification of the ward or room, of everything about the operation-table or bedding, of the patient herself, and the parts near the seat of operation, of the surgeons, assistants, and nurses, and of all the instruments, sponges, and water used, had gradually become complete before carbolic acid was used." Gentlemen, this would do for part of a clinical lecture on aseptis.

In another place he says he did not attend *post-mortem* examinations, and he advised special operation-rooms for abdominal sections, where dangers of

contact with other patients were reduced to a minimum. He also guarded against contagion being imported by spectators. At that time our knowledge of germs was very small. We only knew they were ubiquitous. Even in the middle of the Atlantic it was said they could be found, but sparsely compared with the myriads prevailing in foul kennels, dirty hospitals, or wherever septic matter abounded. A single germ-obtaining entrance to a wound was considered sufficient to upset matters, and to explain all or any after untoward results. The stoppage of the spray during an operation was looked upon as a calamity, and reserve sprays were kept at hand so that the cloud of carbolic spray that enveloped the seat of operation and everyone who approached it was maintained impenetrable. Wounds and viscera were irritated and chilled by the spray, especially by the foot spray, and no doubt deaths occurred through the action of the spray on the intestines. Sir Spencer Wells used the spray in 1878, but, mark his modification, he put a large sponge over the intestines, so that they would not be injured by the spray. Here again, he seized the weak point and corrected it, and was able to do still better by the antiseptic methods than by his older methods. As surgeons and gynaecologists became accustomed to the improved statistics of antiseptic surgery, so they became dissatisfied with the irritation of the tissues produced by antiseptic dressings, and a variety of antiseptics—enmeshed wools, gauzes, &c.—were tried in succession without arriving at a satisfactory issue. Meantime, the science of bacteriology had developed. Germs were classified; their habits and their habits ascertained, and it became known that there were germs and germs, pathogenic and non-pathogenic germs, that ordinary pure air did not as a rule contain pathogenic germs. Whilst Tait and others were declaiming against the germ theory of disease, because they found they could get good results without carbolic acid, bacteriologists were gradually placing that theory on a foundation of rock, and surgeons were learning that the spray was unnecessary, that there was no use in firing volleys of antiseptics at random here, there, and everywhere, doing as much harm as good. Hence arose the present aseptic system of treating wounds. The aseptic system explains the pre-antiseptic successes of Wells and the rival claims of Tait, Bantock, and all the apostles of cleanliness, who worked well and successfully without admitting the germ theory. I would say that empirically such operators had unwittingly lighted upon the practice of aseptic surgery.

My esteemed predecessor, Professor Taylor, has referred to the aseptic system in terms with which I entirely agree. It is the highest development of the germ theory of disease, and instead of being as some suppose the downfall of Lister, it is his apotheosis. By no class of operators is the aseptic system carried out more strictly and more successfully than by the gynaecologist, and in no region of the body is it more necessary than in the abdominal cavity, except perhaps in the brain cavity.

The old septic surgery which I have described was full of nightmares to the young surgeon, who agonised over each unfavourable symptom in the fear that something he had done was the cause of the trouble. The older surgeons, more hardened, looked upon pyæmia as the visitation of God, and regarded the issue as a perfectly impersonal matter. In antiseptic surgery our nightmares were fewer. The holding out to the end of the operation of the spray producer was one easily avoided by larger boilers and more sprays. The sponges were, however, a real nightmare. The trustworthiness of the nurse who prepared them was most important; many gynaecologists undertook their preparation personally, and the process of cleansing and asepticising them during operation was both complicated and dangerous. A new untried nurse was a terror to us, and often only enabled us to give a divided attention to the details of the operation until satisfied that the new sponge assistant was trustworthy. Then the sponge count and the delay and

exasperation when any sponges were unaccounted for, and the searching until the missing one was found. With the aseptic system the natural sponges have entirely disappeared, and, instead, we have artificial ones, aseptic, dry, and taped, so that they are always to be found whenever wanted. The purification of everything near or coming into the field of operation is more perfect than before, mathematically perfect, as Professor Taylor so aptly terms the asepticity of the sterilised dressings. To the patient aseptic surgery affords greater comfort and safety, to the surgeon more certainty and greater operative success. The æsthetic feelings of bystanders are more considered in aseptic surgery. The surgeon and his assistants in their blood-stained coats or dressing-gowns, gathered round the operation-table, looked like the denizens of the lower regions. Now the white-robed surgeons, their assistants, attendants, and nurses, might be mistaken for angelic hosts. Of course, in all millinery there are fads and vagaries, and operation-room millinery is no exception to the rule. I do not think we should object to any innovation, however bizarre it may seem at first, if it can be shown to help in the better carrying out of the germ theory of disease, and if its disadvantages do not outweigh its advantages. A fad that reduces the mortality will outlive its scoffers and detractors, and custom will soon render it inoffensive to the spectators.

Gentlemen, I feel it to have been a great privilege to have lived in this period of the world's history, and to have come through this experience and watched the development of so many operations from tentative efforts only occasionally crowned with success, and to have seen failures that required a strong heart to persevere and to try again and yet again, in face of the opposition always levelled at innovators up to the time when the results were declared by all to be satisfactory, and the operations took their places as sound gynaecology. Ovaries, uterus, appendages, can now be dealt with safely. Effusions of blood, pus, or serum in the pelvis can now be treated in such a way that the old Latin words, *tuto, cito et jucundo*, may be well applied to the treatment. This knowledge of how to do these things once belonged to a few special men, but has now become diffused through the length and breadth of the country, and the benefits of aseptic gynaecology are brought, as it were, to the doors of the patients. Thoroughly trustworthy and practically perfect operation-rooms are attached to even the smallest hospitals, and the ambitious practitioners of villages are encouraged to prepare themselves for the higher work of the profession. Operations that Wells and Tait talked of with pride, and that were once looked at by lesser men with awe, are now done away in country districts nearly as safely and as well as these operative giants performed them, by comparatively young and inexperienced men fresh from the operation theatres of their student days. At one time our wisest teachers impressed on the students the necessity of attending to the common diseases and to the ordinary methods of treatment in preference to gazing at operations that they would probably never see after leaving the schools, and would much less have in the future any chance of performing. Now, with safe and sanitary hospitals everywhere, cottage or otherwise, every man may become an operator, provided he has prepared himself for that work and is able to take advantage of the opportunities that are now afforded in most localities. I have been surprised at the excellence of the gynaecological as well as surgical work performed in small hospitals, and the valuable assistance that can now be obtained in out-of-the-way places from men whose surgical instincts are kept fresh and keen in their small hospitals, and in striking contrast to men of a more remote date whose surgical training was soon forgotten, and who constitute a danger rather than a help to an aseptic surgeon when their services are the only available assistance upon which he can rely. We have advanced so rapidly in gynaecology that none but the newest editions of the best books are of practical use. An excellent nurse, and up to date when she left

hospital a very short time ago, is now quite behind the times and requires to come back to the wards occasionally to learn the new *technique*. Only the hospital surgeons who live on the top of the waves are able to pick up and use all the treasure trove continually being thrown up from the ocean of truth.

In this rapid retrospect I have referred to the germ theory and the development of its practical application to wounds as the central and main feature of the numerous improvements in surgery and gynaecology that have taken place during my professional life. There are other improvements that have accentuated the success of both the antiseptic and aseptic treatment in gynaecology. Some of them are strokes of genius, so simple and obvious are they, and yet of such sterling value. Foremost among them I would mention the Trendelenberg position in pelvic operations. Whoever has performed or witnessed an operation in a deep pelvis with persistent raids of intestines invading the field of operation in spite of the efforts of assistants to keep them back, their obscuration of the diseased spot, and the necessary stooping over to pierce the depths of a narrow hole to find a bleeding point, must feel thankful to Trendelenberg at every operation he now performs when he sees the intestines rolling back naturally by the force of gravity into the abdomen, the pelvis freed from their presence, and the diseased structures lying exposed, clear and convenient to his manipulations. In all operations in the abdomen, the position of the patient is of primary importance, and the simplicity and ease of all procedures are much increased. When intestinal coils extruded themselves from the abdominal cavity in former times, their return was accomplished by pushing them in, and this sometimes was a difficult and harmful task. Now we take advantage of gravity, lift up the abdominal walls and allow the intestines to flow back unhandled and uninjured. Then with improved clamps and pressure forceps, the hæmorrhage is anticipatory, and the amount of hæmorrhage during an abdominal operation is trifling, and is rarely a factor in the prognosis of the case. The necessity of leaving the peritoneal sac perfect as it exists in Nature is now well understood and always acted upon, but failures to cover raw surfaces led to many fatalities in the past. The avoidance of post-operative hernia by the methods of closing the opening in the abdominal wall, and the value of time in increasing or in diminishing the shock of an operation is so well understood that all surgeons now go straight ahead, using the appropriate means in orderly sequence, so that not a moment is wasted. In a well-regulated hospital a dozen operations may now be done in an afternoon, any one of which would have served our forefathers for the greater part of the time.

It may now be said, What more can we do? Is gynaecology exhausted as a field for enthusiastic and ambitious men? Some years ago I was reading a book on "Exploration of the Polar Region," and I came across a statement by one who afterwards became one of the old sea-dogs of the time of Elizabeth. He joined a ship bound for the Arctic Circle, and the reason he gave as to why he joined that branch of navigation was because all other sciences were shut to him since all possible discoveries had been made both in science and art, and there alone remained, to men of liberal education and leisure who wished to make a name for themselves, the Arctic region and its mysteries. We who know what has happened since then in every science and art know how vain was this statement. Our successors in 2005 may, in reviewing the past, talk about the backward state of surgery in 1905, and of our blindness in not seeing improvements that in 2005 may seem so obvious and so easy. Gentlemen, the history of the past teaches us that if we desire any discovery, and work and watch earnestly and unweariedly for it, that discovery will sooner or later be made. The discovery may not be made by the accredited seekers after it, but it may be by improvements and appliances in another branch of work altogether. How often have surgeons desired to see through the tissues to know where bullets were, and lo! a present

is made to the surgeons by a physicist of the very apparatus desired. We have found the cause of consumption which many generations have desired in vain, we can isolate and cultivate the tuberculous bacillus; that our knowledge does not aid us much as yet in curing phthisis is only a detail which will soon be filled. Without going further into the delightful field of the laws that govern discoveries, let us see what we want as gynaecologists. What are likely to be the fruits of the twentieth century in the matter of diseases of women?

I hope one of the events of the twentieth century will be a lessening of the mortality of cancer of the uterus. According to the Registrar-General in 1902, 3,869 women perished from this disease. Many of them die at an age when a growing family most want their mature wisdom and tender control in launching their offspring upon the world. At the present time the only promising treatment is to remove widely the diseased part. Hysterectomy can now be performed with such a very low mortality that the risks of the operation are small when compared with the results of the disease. Very few cases, however, come into the operator's hands in a sufficiently early stage to test the good effects of early operation. During the six years ending December, 1901, and of which I have the statistics of the female surgical wards of the Liverpool Workhouse Hospital, 98 cases were admitted with inoperable cancer, and died there within a variable time. Several causes may be assigned for the delay. First, the impression often entertained that the hæmorrhage from a cancer is the change of life, that it is hence of no great importance, and will cease spontaneously when the change is complete. Practitioners of medicine in the past often favoured the popular idea and gave ergot, &c., until the condition of the patient made this diagnosis no longer tenable. Secondly, the difficulty of diagnosis in the early stage. Curettings and fragments, when examined by skilled pathologists, generally leave the surgeon in the same state of doubt as he is in from clinical evidence, and if he decides to wait, the patient is so willing that she generally waits too long. Then if the case be still operable and an operation be performed, the disease soon recurs. What we want is a simple and certain test by which *at an early stage* we may recognise cancer and operate in good time. When the disease is advanced the most extensive operations are often worse than useless. Should a woman, æt. 50, have a foul, sanguinary discharge from the uterus, be losing colour, flesh and appetite, I would feel inclined, if the patient and her friends agreed, after full explanation, to remove the uterus freely whilst yet movable, and take the risk of it not being cancerous. The clinical evidence is so much more certain than the microscopical, under the conditions that generally exist in these early cases, that the surgeon would seldom be far out. He would remove safely an organ whose work is done, the existence of which is a menace to the life of the patient. The various organised researches into the nature of cancer that are both numerous and well equipped will perhaps throw some light upon the nature of the disease that our diagnosis will be more trustworthy and our operations more prompt, if, indeed, the cure of the disease will in future be through any operation. I have tested various sera in the treatment of inoperable cancers of the uterus and other places. In one case of cancer of the uterus the disease appeared to be delayed for about a year. At the end of that time it carried the patient off in a few weeks. The microscope did not show any alteration of the usual growths of the cancer cells.

The nervous diseases of women are in a state of great confusion and uncertainty. For instance, one class of gynaecologist may examine a patient suffering from definite pain and symptoms, and declare there is nothing the matter with her except hysteria or neurasthenia. Another may examine the same woman, find a small cystic or fibroid ovary which he may remove, and completely and permanently cure the patient, or the relief may only be temporary, the old symptoms returning perhaps with renewed force, and the patient now able

to blame the operator for all the symptoms she may at any time suffer from. We all know of cases of women who have suffered not only much pain and physical distress from disease, but also great mental distress from being labelled a neurasthenic or a hysterical individual by the doctors, in the first instance, and by their husbands, parents or other near relatives, but in quite a different sense. When a medical man diagnoses neurasthenia or hysteria he knows his patient is suffering from a disease. The friends and relations only understand that she has nothing really the matter with her, that she is a malingerer, a humbug, a teller of untruths. The confidence and affection of married life is destroyed, and the results in family life are deplorable. These diseases require careful study, they require to be classified and their treatment formulated. Were this done, many brilliant women who fizzle out into hopeless invalids would be saved to themselves, their families, and friends.

Uterine displacements arise most frequently after strain, miscarriages, and confinements, and in the early stage these misplacements are capable of replacement and probably of permanent cure. Is our treatment at the present time a rational one, and would it be tolerated in other displacements? A woman has a miscarriage, the fœtus has come away, the hæmorrhage has ceased, and the convalescence is uneventful. How often is it the custom to keep the patient in bed on her back for two and three weeks, then allow her to get up and go about until she begins to complain of pains and dragging, and then a fixed incurable retroflexion is found, and perhaps an operation is necessary to cure her. In such a case the uterus has only developed in the fundus. When the contents are expelled, the fundus is enlarged and the cervix is soft, top heavy and falls back, the intestines roll in front of it—that is, on the anterior or inferior surface instead of the posterior or upper. The patient is kept on her back, a position that tends to retain and to increase the displacement. After the fortnight or three weeks of the dorsal position, the patient is allowed up, the uterus is at this point in a state of retroversion, the erect position and the pressure of the abdominal viscera upon the fundus, together with the relaxation of tissues due to the rest, soon produces the pathological retroflexion that by its symptoms demands the attention of the gynæcologist. More minute attention to the condition of the uterus would detect the threatened displacement soon after its occurrence. Simple reposition would probably cure many incipient cases. With the prone or semi-prone position maintained while necessary, other cases would be cured. The assistance of a Hodge might be required in others. The erect position is the most secure one for a healthy uterus, as that organ then lies well forward on the bladder with the pubic symphysis beneath, and both its utero-sacral and round ligaments are in a healthy state of action and interaction. But what do we see in practice? Women who are supposed to have a tendency to displacement sit down at every opportunity if not all day long on a comfortable reclining chair or sofa and put their feet up, the best possible position for relaxing all the muscles and allowing the uterus to slide down to the bottom of the pelvis. It gives relief, I grant you, but it perpetuates and accelerates the tendency to displacement. After confinements, abortions, strains, any changes in the position of the uterus should be looked to just as carefully as we examine fractured bones, and reduction should be effected and maintained at the earliest possible moment. The causes of many cases of displacement are involved in obscurity, and urgently require elucidation.

Gentlemen, in this imperfect sketch of my experience of the rise of gynæcology, I have omitted two circumstances that fostered the growth of the specialty most materially—I mean the foundation of the British Gynæcological Society and the influence of its *Journal*. The Society has brought men of like instincts together, where due time is obtained to discuss their common scientific interests, and the valuable *Journal* has carried these discussions to a wider circle than are able to

attend the meetings. The choice gleanings from other journals are most useful, and I have often obtained valuable information as well as inspiration from its pages. May it be said of both the Society and the *Journal*—

“That which they have done is but earnest of the things that they shall do.” Longfellow tells us how to do it:

“Let us then be up and doing,
With a heart for any fate,
Still achieving, still pursuing,
Learn to labour and to wait.”

A NOTE ON

ANTE-MORTEM CLOTTING IN THREE OF THE CHAMBERS OF THE HEART, AND OTHER CASES OF CARDIAC THROMBOSIS.

By F. PARKES WEBER, M.D., F.R.C.P.,

Physician to the German Hospital, and to the Mount Vernon
Hospital for Chest Diseases, Hampstead.

THE patient, K. Tr., a somewhat thin and anæmic-looking man, æt. 45, was admitted under my care at the German Hospital on October 6th, 1904. The history was that for eight days he had had some œdema of the legs, and for three days had been oppressed with dyspnoea and cough. During the last six months he had been much troubled with pains in the gastric region, and during that period had become decidedly thinner. Twenty years ago he had been laid up with a severe illness, apparently typhoid fever, in a hospital in Germany. Otherwise he had always been well, and he denied excess in alcohol. He had been married fourteen years and had had five children, three of which were living. One of his parents died at seventy-eight years of age; the other was still living, aged seventy-two years.

In the hospital the patient was found to have enlargement of the heart and liver. The cardiac impulse was diffused and could be felt two inches outside the nipple line; there was no murmur. Wheezing sounds were heard over the lungs. The patient's expression was anxious and pinched, as it often is in myocardial affections. There was slight œdema. The urine was at first about normal in quantity, of specific gravity 1020, and containing a trace of albumin and a sediment of urates; hyaline casts were detected. Afterwards albumin was sometimes absent.

The patient was treated by rest, and drugs such as strophanthus, digitalis, squills, &c., were tried, but his condition gradually became worse. There was a good deal of pulsation in the jugular vein. Never any fever. On November 30th the pulse could hardly be felt at the wrist, there was more cough, and crepitations could be heard all over the lungs. He died on the afternoon of December 2nd, 1904.

At the *necropsy* the heart weighed twenty-four ounces and all its chambers were dilated. There were a few epicardial petechiæ about the apex. No pericarditis. There was partly decolorised *ante-mortem* thrombus in both ventricles, chiefly near the apices and in the right auricular appendix. The left auricle was free. There was no valvular disease except some old thickening of the mitral cusps. Part of one of the trabeculæ in the left ventricle was calcified. The great dilatation of the right auriculo-ventricular orifice accounted for the jugular pulsation observed during life. The coronary arteries were in places slightly atheromatous and stenosed, but, on the whole, not greatly

diseased and not thrombosed. The aorta showed moderate atheromatous changes. Microscopically the walls of both ventricles showed a diffuse chronic interstitial fibrosis with degenerative changes in the muscle fibres.

There was moderate hydrothorax on both sides and some ascites. No pleurisy. The lungs showed the changes of chronic bronchitis, but no embolic infarctions. The liver weighed sixty-two ounces, and both macroscopically and microscopically was a typical "nutmeg liver." The spleen weighed six ounces, and was of the "cardiac" type, of red colour and firm consistence, but without embolic infarctions. The kidneys weighed together ten ounces and showed the remains of old embolic infarctions, so old, in fact, that, owing to atrophy of the scar tissue, the infarctions were represented almost only by depressions. The capsules stripped readily, and microscopical sections of parts of the kidney not affected by the old embolisms showed practically nothing abnormal beyond passive congestion. The stomach exhibited the ordinary catarrhal changes and a few hæmorrhagic spots in the mucous membrane, such as are found in cases of great passive congestion. The small intestines showed similar changes. In the duodenal mucous membrane, near to the bile papilla, was a small oval nodule, measuring about 2 X 3 mm., which by microscopic examination (a) appeared to consist of sclerosed pancreatic tissue, similar to the aberrant pancreatic tissue in the intestinal walls described by E. L. Opie (b) and others. Near this spot there was a little hæmorrhage in the connective tissue between the head of the pancreas and the duodenum. The suprarenal glands showed nothing special. The bone-marrow of the shaft of one humerus was examined and found to contain red patches, probably due more to congestion and hæmorrhages than to lymphoid metaplasia.

In this case the presence of "cardiac anxiety" and dyspnoea contrasted with the relative absence of certain signs usually associated with chronic cardiac failure, such as œdema and diminution of the quantity of urine. Clinically, the possibility of cardiac thrombosis was thought of. It seems remarkable, however, that the clots in the chambers of the heart gave rise to no pulmonary or other embolisms. The scars resulting from embolic infarctions in the kidneys were of much earlier date, and perhaps, taken in connection with the old thickening of the mitral valve, were to be attributed to a former rheumatic endocarditis, of which we got no history, but which may have been contemporary with the commencement of the chronic interstitial myocarditis ("myofibrosis cordis"), a cause of cardiac dilatation and cardiac failure much more talked of than actually seen.

In 1897 I described the case of a man aged fifty years (c) with mental hebetude and cardiac failure. After his death the heart was found to weigh twenty ounces; it was dilated and contained granular thrombus in three of its chambers, namely, as in the present case, in both ventricles and the right auricle. The cardiac valves showed

no disease excepting slight atheromatous changes. There was no history of great indulgence in alcohol. Of the four cardiac chambers it is probable that the left auricle (a) is the one in which *ante-mortem* thrombus least often forms.

These cases differ somewhat from those of globular thrombi with subtrabecular ramifications, (b) of which I had a typical example in 1902. The patient was a woman, æt. 42, with an aortic diastolic murmur, who had suffered from articular rheumatism when twenty years old. A few months before her death she began to suffer from attacks of "thoracic anxiety," with dry cough and feeling of being suffocated. In the hospital she had frightful paroxysms of dyspnoea, and had blood-stained expectoration. Resonance was impaired over the base of the right lung, and crepitations were heard over both bases. There was slight fever at the end. After death the heart was found dilated and weighing sixteen ounces. The left ventricle was hypertrophied, and the aortic semi-lunar valves were thickened and contracted. A number of somewhat globular or faceted thrombi, varying in size from a small pea to a large hazel-nut, were attached to the trabecular meshwork of the right auricle (chiefly the auricular appendix). The liver and other organs showed signs of chronic passive congestion and a considerable portion of the lower lobe of the right lung was solid (embolic infarction?). The globular thrombi in the auricle consisted of an outside shell (doubtless fibrinous), filled with a reddish, thick creamy ("puriform") material, which under the microscope was seen to be granular debris with an admixture of white cells. Much has been written by Bristowe (c) and others on softening clots of the heart. Perhaps the central softening which so often occurs in globular thrombi is due to the infiltrating leucocytes exercising a digestive or proteolytic action on the clotted blood. In regard to this softening of cardiac thrombi, Mr. Shattock has kindly directed my attention to the softening which Mr. C. A. Ballance (d) found to occur in the interior of aseptic thrombi after ligation of blood-vessels.

Therapeutic Notes.

APPENDICITIS AND MINERAL APERIENT WATERS.

By DAVID WALSH, M.D. Edin.,
Senior Physician, Western Skin Hospital, London, W

At the present time appendicitis is the subject of great public interest and curiosity. On all hands the medical practitioner is assailed by questions as to its origin, its course and its treatment. Its very name has been abandoned by some surgeons in favour of perityphlitis. Curiously little is really known as to its ultimate causation, although the general conclusion appears to be that the localised inflammatory process is of microbial origin, and that, again, is connected with constipation as a precedent or associated condition. Few pathologists probably would venture further than that in our present state of knowledge. Yet there are plenty of writers ready to rush in where "angels fear to tread." The public

(a) I have to thank the house physician, Dr. Blendinger, for microscopic sections of the organs.

(b) "Diseases of the Pancreas," 1903, pp. 46 *et seq.* J. H. Wright ("Journ. of Boston Soc. of Med. Sciences," 1901, vol. v, p. 487) describes a small "aberrant pancreas in the region of the umbilicus," removed by operation during life.

(c) "Trans. Path. Soc.," London, 1897, vol. xlviii, p. 62.

(a) See Bristowe's conclusions on "Softening Clots in the Heart," "Trans. Path. Soc.," 1863, vol. xiv, pp. 71-83.

(b) See W. Osler, "Johns Hopkins Hospital Reports," 1891, vol. ii, p. 56.

(c) J. S. Bristowe, "Trans. Path. Soc.," 1856, vol. vii, p. 134; 1863, vol. xiv, p. 71; and 1868, vol. xix, p. 90.

(d) "Ligature of the Great Arteries in Continuity," 1891.

newspapers and journals have been flooded with all kinds of grotesque and fantastic literature upon the subject of appendicitis, not infrequently above the signature of a medical man. A curious production of the kind appeared lately in one of the most famous of our monthly reviews. (a)

The author of the remarkable article in question announces as one of the chief causes of appendicitis the use of "Hungarian waters, aperient salts, and liver pills." His absolutely gratuitous assumption is based on an equally improved theory of the action of saline purgatives, namely, that the watery flow leaves solid matter behind to accumulate in the cæcum, and, by subsequent putrefaction, to set up inflammatory mischief in the neighbourhood of the appendix. As a matter of fact, solid accumulations in the cæcum are rare under any circumstances, and although small fæcal concretions are sometimes found in the vermiform process in appendicitis, yet they are, on the other hand, just as often conspicuous by their absence.

Appendicitis, again, is three or four times more common among men than among women. But women are more prone to constipation, and, therefore, use more aperients; possibly the latter fact accounts for the lesser incidence of appendicitis upon their sex. Any way, the sex-incidence alone is sufficient to upset the writer in the review, not to mention the further fact pointed out in the *Lancet*, (b) namely, that the age at which the malady usually occurs is from ten to twenty years, which is not the period of life at which purgatives are generally taken. On such scant foundations as those above indicated it seems incredible that a medical writer should condemn the use of aperients.

As a matter of fact, it is likely that aperients, especially the Hungarian bitter water which the writer so much resents, form the best preventive treatment of appendicitis. In a host of cases of chronic or recurrent constipation the morning draught of Hunyádi János forms the sheet-anchor of the medical attendant. From every point of view the wholesale condemnation of so valuable a remedy in the pages of a prominent review is much to be regretted. The harm that may be effected by the circulation of such statements is incalculable. It is a thousand pities that a responsible lay editor should have permitted a technical theory of this kind to appear in his review. Its fitting place for publication would have been one of the medical journals, where it would have been duly weighed in the professional balance, and its claims to consideration promptly decided.

But it is not only by way of prevention that mineral waters such as Hunyádi are valuable. As every practical physician knows, they constitute our great therapeutic weapon in the large class of cases where the symptoms are early and mild, and where it is reasonable to anticipate relief or cure without the aid of the surgeon. In such cases a wineglassful of the aperient water can be given every morning. In cases where appendicitis has shown itself, but has not recurred, the same remedy can be used every other morning for months together. In recurrent cases the question of operation always demands most serious attention. As a preventive measure in cases of chronic constipation a similar course

can be adopted. Something of the kind is specially indicated when examination shows the blood to be defective, or when the patient suffers from dyspepsia or other gastric troubles, or is engaged in a sedentary occupation. To a certain extent the use of a natural saline aperient water may be made to compensate unfavourable conditions in the individual, as, for instance, over-feeding, excess in alcohol, want of exercise, the gouty or rheumatic habit, and, generally speaking, depressing or harmful factors of the modern civilised environment which are prone to lead to impairment of the ordinary physiological functions of our daily life.

Clinical Records.

CASES OF FIBROMA AND OF CARCINOMA OF THE OVARY. (a)

By H. MACNAUGHTON-JONES, M.D.

Fibroma of the Ovary.—A specimen of true fibroma of the ovary was shown to the Gynæcological Society on February 9th. It was removed from a patient, æt. 38, who suffered from ascites. As a tumour could be felt through the vagina, abdominal exploration was advised. The patient was very obese, and on evacuation of the ascitic fluid, a large and hard liver was found. On examination of the pelvis, the ovarian tumour was discovered at the left side. The Fallopian tube was unaffected, and the uterus was healthy, as were also the adnexa of the opposite side. The following was Dr. Cuthbert Lockyer's report:—

"The tumour is a typical fibroma growing from the outer pole of the ovary. It is composed of interlacing bundles of dense fibrous tissue showing very distinct nuclei. The inner pole of the gland presents a stroma of varying consistence, thick-walled blood-vessels, small cystic spaces, several corpora albicantia, but no normal-looking Graafian follicles."

The tumour agreed with the description he (Dr. Macnaughton-Jones) had given in the last edition of his work, namely, "a smooth, lobulated mass, greyish-white or marbled, rarely dotted with cystic degeneration." It would be noticed that at one end of the tumour as shown by the microscopical sections on the table, there were some cystic spaces. The tumour had no proper capsule in the ordinary acceptation of the term, as, for instance, in uterine fibroma, the tunica albuginea being involved in, and incorporated with, the growth. As usual, only one ovary was affected, and the tube was healthy. The exact source of origin of these tumours appeared to be uncertain, but it was thought that the growth commenced in the embryonic tissue round the follicles. The tumours were usually small, as in this case, the larger sizes being of a fibro-myomatous nature. Up to 1902 Peterson had collected some 82 cases. Dr. Macnaughton-Jones has met with one other instance of true fibroma, the particulars of which he had brought before the Obstetrical Society, and which had been recorded in his work. The ascites in this case was, he believed, caused by the hepatic affection, and had nothing to say to the fibroma.

Carcinoma of the Ovary.—The patient from whom the tumour was removed was æt. 45. She was a nullipara, married for twenty-five years. One brother had died of cancer at the age of forty. The patient had always been a robust woman, and there had been no symptoms of any kind calling for special comment up to a period within six weeks of her operation. She then had an attack of parametritis, when a myomatous uterus was discovered, reaching about half-way to the umbilicus. For this she was treated, but her symptoms continuing, an examination under anaesthesia was made some three weeks subsequently, when a mass was found towards the left side, which was believed to be a pyo-salpinx. There was nothing in the appearance of the patient or her condition

(a) *Nineteenth Century*, January, 1905.
(b) *Lancet*, February 11th, 1905, p. 872.

(a) Notes read at the meeting of the British Gynæcological Society February 9th, 1905.

to suggest malignancy. There was pain, but it was not severe. The catamenia during the last two years had been uncertain, the last period having occurred three weeks previous to the onset of her inflammatory attack, and the one before that ten months previously. A severe attack of peritonitis ensued in the fourth week of her illness, and on its subsidence he operated. The tumour was found behind the myomatous uterus, to which it was adherent, as also to all the surrounding structures. Its isolation and removal were very difficult but were successfully accomplished without accident. The tumour was then found to be the ovary, the centre of which had necrosed and broken down into pus.

"The specimen was a very degenerate carcinoma of the ovary. No part of the tube could be found in the necrotic mass. Microscopically, there was a stroma of fully formed fibrous tissue. In the latter there were alveolar spaces in which the carcinomatous cells were packed. Most of the latter were degenerate and shrunken."

There did not appear to be any involvement of the surrounding parts, nor of the opposite adnexa. The patient stood the operation well under chloroform anaesthesia, but the temperature range only twice reached the normal line, and notwithstanding injections of artificial serum and strychnine, with other measures, she died within sixty hours after the operation. Her condition was, of course, desperate before its performance. The noteworthy feature of the case was the complete absence of symptoms, and the apparent good health of the patient up to so recent a period. Mr. Charles Ryall had rendered him valuable assistance during the operation.

Transactions of Societies.

ROYAL ACADEMY OF MEDICINE IN IRELAND.
SECTION OF OBSTETRICS.
MEETING HELD FRIDAY, FEBRUARY 3RD, 1905.

The PRESIDENT in the Chair.

SPECIMENS.

DR. ALFRED J. SMITH showed a rare specimen—a large physometric uterus. The patient was delivered early in last October of twins (at the sixth month), both dead, and beginning to decompose. On the fourth day after delivery she had a severe rigor, with temperature of 106° F. Her local doctor washed out the uterus with a weak corrosive sublimate solution. Notwithstanding this, her condition went from bad to worse. On admission to St. Vincent's Gynaecological Department she was in evident distress from distension—temp. 102.6°; pulse, 120. Examination under ether was unsatisfactory, as nothing could be mapped out. The diagnosis was not made until the abdomen was opened. The numerous discoloured, gangrenous-looking patches which were demonstrated influenced the decision in favour of removal. A hysterectomy was performed, fortunately without rupture. Examination of the contents was postponed, as Dr. Smith wished to show the large uterus in its distended condition. Uninterrupted recovery.

DR. KIDD wished to know how the gas had been kept in the specimen? The only similar case he had seen was an accumulation of gas inside a gestation sac. The patient came into hospital three months pregnant, with symptoms of threatened abortion. The symptoms abated, and she went out. He saw her again when she was thirteen months pregnant. The whole of the front of the abdomen was perfectly dull. A rectal examination was made, and next day her temperature was 104°, and the abdomen very resonant. An operation was performed, and it was found that there had been a primary rupture into the layers of the broad ligament, and the gestation sac had gone on developing. There was an escape of very offensive gas on the sac being opened. The patient made a good recovery, and had had two children since. The only explanation

he had for the formation of the gas was that the bacillus coli communis had got into the gestation sac on account of the rectal examination.

DR. PUREFOY said that most of them had seen the condition termed physometric in connection with malignant disease, or in cases of delayed or neglected labour, where air had got into the uterus. Dr. Smith's case was remarkable on account of the gas having remained in the uterine cavity.

DR. E. H. TWEEDY showed an ovarian cyst.

DR. PUREFOY read a paper on

TWO CASES OF CYSTIC ENDOMETRITIS, WITH REMARKS ON TREATMENT.

DR. HASTINGS TWEEDY said that cystic endometritis was a disease he did not know personally, and of which he could find no account. He objected to fresh nomenclature, and thought they should stick to the term glandular. His objection to the term "cystic" was that it did not lead anyone to a knowledge of what one was dealing with, whilst "glandular" did. The question of treatment was more interesting. A few years ago every case was curetted, but of late there had been a reaction against this, and many now preferred to use intra-uterine douches, caustics, &c. He protested against this, and believed that in his study practice the surgeon had little right, and rarely necessity, to pass anything into the uterus. It was impossible to be aseptic in study practice. The vast majority of cases of endometritis, especially the hypertrophic form, were cured by one cleanly curetting. He left his cases alone after curetting, and did not use medications subsequently. He washed out the debris with salt solution, and did not use antiseptics, which devitalised the tissues, and the less the uterus was irritated with them the better. He could not understand the *raison* of taking a patient in every third day to inject iodised phenol after curetting; it seemed to him unnecessary and dangerous. The less often the uterus was entered the better. There was a certain amount of danger in putting anything into it, and if good results were obtained without caustics, why apply them? The term "benign adenoma" is misleading, as it implies growth accompanied by increase in the number of glands, and all such growths of the endometrium will prove in practice to be malignant.

THE PRESIDENT said he divided endometritis into glandular and interstitial. There were two kinds of glandular—hyperplastic and hypertrophic. Hyperplastic was adenoma, and in it there was an enormous increase in the number of glands: hypertrophic had a normal number of glands, but greatly increased and distended, and which, when occluded, formed cysts. The hyperplastic frequently became malignant, therefore these cases had to be seen often, and the uterus removed. The hypertrophic might be merely distended tubes, or, if seen late, cysts. The treatment was to mechanically remove the mucous membrane, and try to cultivate a healthy mucous membrane. Try to find out the cause of the endometritis. His practice was to curette and wash out once, and wash out again on the third and fourth day to see that nothing was left behind. He used hot sterilised saline solution, and did not employ any intra-uterine medications.

DR. PUREFOY, in replying, said he thought it was of importance for them to study the pathology of these conditions for themselves, and if systematic examination were made in every case good practical results would follow. With regard to the objection to giving the condition a special name, he could not agree with Dr. Tweedy. The condition was one of considerable rarity, and most of the manuals did not allude to it at all. He believed that the condition was not a very advanced stage of glandular endometritis. He did not know what caused it, but thought that if it had been at all common, he would have met with more than two cases of it. The term cystic endometritis was employed in two classes of cases—in gynaecological cases, where the patients were not pregnant, and also a diseased condition of the endometrium occurring in pregnant women. His cases occurred in women apart from pregnancy. The epithelium in the dilated glands was not

in the atrophied condition you would expect it would be from pressure; it was intact. He believed the condition was very rare. With regard to subsequent treatment, he thought it was in the patient's interest to use a mild caustic four or five days after curetting, and its subsequent use was to be determined by the amount of discharge, condition of cervix, character of first menstruation, &c.

OBSERVATIONS ON BOSSI'S DILATOR, WITH NOTES OF FOUR CASES.

Dr. ALFRED J. SMITH set out the views of the rival schools which indicated that Bossi's dilator had not met with universal approval or adoption. He considered it to be the duty of each to assist in determining this question—what is the place this dilator holds in an armamentarium. Dr. Smith is convinced that, within certain well-defined limits, it has a distinct position, but these limits must be clearly defined. Of his four cases—three for eclampsia and one for placenta prævia—all were successful; the entire time between the introduction of the dilator and the end of the third stage did not exceed one hour. There was an extensive laceration of the cervix requiring stitches in the placenta prævia case. He considers Bossi's dilator dangerous when the cervix is long, and not taken up, especially in cases of placenta prævia. The close proximity of the uterine sinus adds a new danger should the laceration unfortunately extend to or open them up. He dwelt on and discussed the question of dynamic action. One great difficulty confronted him—how much dilatation would be necessary to deliver the foetal head at the sixth or seventh month? And in order to formulate a basis for accurate observation, he drew up a scale for his guidance based on the relative circumference of the S.O.B. diameter during these months.

Dr. KIDD said that one disadvantage of Bossi's dilator had been met by changing the number of blades from four to eight, thus having eight points of pressure on the lower zone of the uterus, and less probability of rupture. An advantage of Bossi was that you could watch digitally the amount of tension between the four blades, which was hardly possible when eight blades were introduced. Another objection was that the angle at which the dilator was set to the shaft was not the angle at which dilatation would take place. Seigneux tried to meet this objection in his dilator, but it had its disadvantages also. There was too much resiliency in the lateral blades, and in order to try and gain the advantages of having eight blades you had to change the blades and insert blades with broader flanges, and this was a very troublesome proceeding. He was quite sure that where mechanical dilatation was used for placenta prævia, the risks of laceration were greatly increased. He certainly thought that its use in eclampsia would give happy results.

Dr. FITZGIBBON said he had used Bossi's dilator in a case in which he had induced labour at seven and a half months. He started by using bougies, but the uterus took on no action, and they were introduced again the day following. The membranes had then ruptured, and the following morning he decided to dilate the cervix, into which he could introduce two fingers. He dilated up to 7 cms. He did not intend to complete delivery, and left the patient, having put some gauze in the cervix. Labour set in in three hours, and she was delivered three hours afterwards. He considered that labour had been induced by mechanical dilatation, which started uterine action.

Dr. HASTINGS TWEEDY said he could hardly think that dilators had been responsible for the salvation of even one woman. Medical papers nowadays teemed with the praises of mechanical dilatation of the cervix in the treatment of eclampsia. He had treated within the last fifteen months ten cases of puerperal convulsions in the Rotunda Hospital with one death; in this case the diagnosis of eclampsia was doubtful. In a large number of these, it was observed that convulsions became severe after the birth of the child, so that the emptying of the uterus could not be considered a save-all and cure-all. In but one of the suc-

cessful cases was delivery accelerated even by forceps, in the others labour was allowed to go on naturally, and finish. These results show that recovery will take place even though violent means to extract the foetus are not adopted. As to the dilator's usefulness in ante-partum hæmorrhage, due to placenta prævia, he must dissent from the views of those who recommended its employment; in such cases the cervix often tears without one being conscious of the fact. The treatment could never compare favourably with the plan of bringing down the leg and leaving the case to Nature. The cervical epithelium is bruised during the process of forcible dilatation, and such bruising predisposes to sepsis. There was one class of case in which he thought the dilator was sure to be applied—"rigid os"—but its use in such cases was sure to be repented of. Bossi himself counted the condition as a contrary indication. Seigneux's instrument appeared to have some slight advantage over the other dilators; but if one desired to open the cervix, it could easily be accomplished by any one of the lacerating instruments at present on the market.

Dr. PUREFOY said that the range of utility of a dilator was not at all as wide as they had been led to believe. The utmost caution was necessary in its use, and the cervix was often found lacerated without it having been noticed. In cases of eclampsia it might sometimes be of use, but the number of cases was very small. It was useful in cases where labour had started, and the pains had come on and afterwards stopped.

The PRESIDENT, in replying, said he had tried the dilator, having heard and read so much about it. He thought that it was in places like Dublin that the principles of new inventions should be tested, as they had to report on them to country practitioners. As to its use in eclampsia, he thought that certain cases would get well no matter what form of treatment was used.

BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD FEBRUARY 9TH, 1905.

Dr. WILLIAM ALEXANDER, President, in the Chair.

Dr. MACNAUGHTON-JONES showed a specimen of Fibroma of the Ovary and one of Carcinoma of the Ovary, and read notes, which will be found on page 187.

Dr. HEYWOOD SMITH asked for an explanation of the absence of the capsule in the first specimen. Had it become involved in the fibroid degeneration?

Mr. CHARLES RYALL, who had assisted Dr. Macnaughton-Jones in operating on the second case, alluded to the very extensive intestinal adhesions, and mentioned a case in which he removed an ovarian tumour with cystic degeneration from a woman fifty years of age, who was suffering from intestinal obstruction. He found secondary deposits in the ileo-cæcal valve.

Dr. HUTCHINSON SWANTON said that the frequency with which ascites was associated with solid ovarian tumours was well known, but in 1902 Demons, of Bordeaux, had reported cases in which there was extensive effusion of fluid, the patients were reduced to the last extremity when the abdominal cavity had been explored, and a fibroma of the ovary detected and removed, the patients recovered. He asked whether there had been any fluid in the pericardium or pleura in Dr. Macnaughton-Jones' case.

Mr. BOWREMAN JESSETT said that some years ago Mr. Lawson Tait asserted that out of every ten ovarian or abdominal tumours with marked ascites, nine were malignant, and he had himself seen a large number of cases of that description. On the other hand, fibrous tumours were seldom accompanied by ascites.

Dr. INGLIS PARSONS said that in two cases the ascites had been so enormous that the diagnosis made had been ovarian cystoma; indeed in all malignant abdominal tumours he had seen there had been ascites except in one, an ovarian tumour not adherent, and removed quite easily. Rapid recurrence took place,

and the woman died in a fortnight. The tumour was a sarcoma.

Dr. MACNAUGHTON-JONES, in reply, said that there was no capsule to the fibromatous tumour in the true sense of the word "capsule," the tunica albuginea being incorporated with, and involved in, the fibrous tissue of the tumour. There had been no pelvic pain. The ascites, he considered, had nothing to say to the tumour, but was due to the condition of the liver, which he considered to be an alcoholic one.

In the case of the carcinoma, neither the uterus nor the ovary was involved, and he believed, though there was no opportunity of having an autopsy, that the change was a primary one in the ovary. The absence of ascites was noteworthy, though he had seen different cases in which this condition was absent. It should be remembered that in different forms of cystoma, especially in those of a multilocular colloid nature, and not malignant, if there were any escape of the contents of the cyst into the peritoneal cavity, a certain amount of ascites was generally present. As to the adhesions, the tumour was firmly embedded in these, and on its removal the rectum and cæcum were exposed, the tumour having to be stripped off these.

The PRESIDENT then delivered his Inaugural Address on the "Rise and Progress of Gynæcology," which will be found on page 181.

Mr. BOWREMAN JESSETT, in proposing a vote of thanks to the President, referred to some experiences that illustrated what the President had said. Some years ago, about the "fifties," when he was a house surgeon, it was never thought that the abdomen should be explored. The peritoneum itself was a sacred membrane which nobody encroached upon. He remembered performing his first ovariectomy in the early seventies, in a case of cancer. The ligature he used consisted of a thick whip-cord; the patient did remarkably well, and returned to her work in the fields. Dr. Macnaughton-Jones had referred to the association of malignant cases with ascites. That woman had some ascites, and it was a case of colloid. But she died twelve months afterwards with recurrence of the disease all over the peritoneum. He recollected another interesting case in the early sixties, when first ovariectomy was coming to the fore. In University College Hospital numerous foreigners came to see a very interesting case of supposed ovarian cyst. This went on for some few weeks. On one occasion the physician asked two French physicians to "come and see an interesting case of ovarian cyst in the hospital." In due course he went to the bed where the patient had been lying, but she was not to be found. "Where's my patient?" he asked. "She is in a private ward." "What for?" "She has been delivered of a fine son this morning!" The diagnosis in that case had not been very complete, and he did not think the case was communicated to the foreign physicians. In conclusion, Mr. Jessett remarked with regard to malignant disease of the uterus that if only they could get some simple test by which to diagnose the disease early it would be a good thing. For his own part, he much preferred to remove the uterus and find it was not malignant than to leave doubtful cases alone.

Dr. MACNAUGHTON-JONES, in seconding the vote of thanks, remarked that he had himself passed through all the phases of Listerism, to the modern complete aseptic methods, from the period of Lister's original antiseptic putty, which he had used in some of his own earliest amputations. While it was interesting to trace the progressive development of aseptic surgery from the rougher methods of our ancestors, still, we should not forget how much we were indebted to them for the boldness and skill with which, under great disadvantages, they had accomplished all they had. Dupuytren had said, in the Academy of Medicine at Paris, that the man who performed ovariectomy should be indicted for manslaughter, yet we owed a great deal to Dupuytren. Their President was universally known, and in every foreign clinic his name was in daily use

in connection with the well-known operation associated with it.

THE LARYNGOLOGICAL SOCIETY OF LONDON MEETING HELD FEBRUARY 3RD, 1905.

Mr. CHARTERS SYMONDS in the Chair.

CASES AND SPECIMENS.

Mr. C. PARKER showed a case of Tuberculosis of the Larynx in a woman, æt. 31. The disease commenced during her fourth pregnancy, since which she had been pregnant five times. On three occasions the child was born alive, and on two occasions she had miscarriages.

Mr. CLAYTON FOX showed, for Dr. Frederick Spicer, a case of Diffuse Papilloma of the Vocal Cords; and Dr. Edward Law showed a man, æt. 69, from whom a laryngeal growth was removed twenty-one years ago from the right vocal cord by the late Mr. Whistler. Views as to the present condition were invited. Some members were of opinion that the case was malignant, but the general feeling was that this was not so.

Mr. DE SANTI showed two cases: A woman, æt. 30, shown at the last meeting, with a laryngeal swelling which was thought to be tuberculous, but a microscopic slide since showed that it was undoubtedly squamous-celled carcinoma. The second case was that of a man, æt. 60, with a large mass of malignant glands in the neck, and swelling of the larynx on the same side.

Mr. STEPHEN PAGET showed three cases for diagnosis. The first was a case of fixation of the left vocal cord, and the opinion of the meeting was that this was aneurysm. The second case was one of growth of the right ventricular band. The third was one of growth in the larynx, which was generally regarded as papillomatous, though some members inclined to the view that it was malignant.

Mr. F. J. STEWARD showed a case of Recurrent Ulceration of both Tonsils associated with Lymphadenoma, in a woman, æt. 64.

Dr. F. W. BENNETT showed a specimen and photographs of a Malignant Growth of the Larynx, and a case of nasal ulceration of the septum, for diagnosis. The latter was considered to be a case of ethmoiditis.

Dr. HERBERT TILLEY showed a case of Primary Sore on the Tip of the Tongue in a man, æt. 40. There was slight enlargement of the glands, but no rash. Some doubt was expressed whether it might not have been a simple sore resulting from the irritation of the caustics which the patient had repeatedly applied. It was advised that the patient be put upon antiseptic treatment, and the case reported on further.

Dr. G. CATHCART showed two cases: First that of a patient shown at a previous meeting, Pachyderma Laryngis (? tuberculous), the second being a case of combined Functional and Organic Paresis of the Larynx in a singer, æt. 34.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, February 18th, 1905.

TREATMENT OF PHLEBITIS.

Dr. MARCHAIS, who has particularly studied the above malady, recommends the following treatment: Absolute immobility during the period of fever and for a fortnight after it has disappeared. During this time the temperature must be taken regularly, and if the fever returns another fifteen days' rest must be observed, after which massage and slight movements of the limb may be ordered. For the first five days, passive movement of the toes and foot are made, and the massage should consist of very slight rubbing of the limb without pressing on the veins or removing the leg from the bed. On the fifth day the patient can make the movements himself, and at the end of the first week the muscles can be subjected to the massage, in respecting the region of the large veins. In the following

week the patient can be allowed to sit up in bed and towards the fifteenth day he may take a few steps.

DEAFNESS FROM LESIONS OF THE INTERNAL EAR.

Three signs exist which characterise lesions of the internal ear—vertigo, subjective noises, deafness. Dr. Chavanne gives the following advice for the diagnosis and treatment of this affection:—

If the deafness sets in almost suddenly, it may be the consequence of traumatism, syphilis, or, on the contrary, to some morbid condition such as diabetes, nephritis, mumps, &c. Two varieties of traumatism of the labyrinth may be met with—commotion and wounds; the deafness due to the former may be either temporary, tenacious, or even incurable. Rest in bed and perfect quietness is the best treatment. If after two days improvement is not observed, revulsion should be made over the mastoid process or leeches applied, and at the same time a purgative given and the feet put into a mustard bath.

If at the end of four or five days the deafness persists, the auditory nerve should be stimulated by injections of strychnine subcutaneously.

Nitrate of strychnine, 0.20 grammes;

Distilled water, 10 grammes.

From 2 to 6 drops (2 to 6 milligr. of strychnine) injected each day for twelve days under the skin of the back of the neck. If at the end of this time the audition is improved, the injections will be continued; if not, they will be suppressed. The deafness is incurable.

If the deafness is due to a wound, it must be treated antiseptically, in order to avoid subsequent inflammation of the membranes of the brain. Where syphilis is suspected, either acquired or hereditary, large doses of the specific treatment must be given. In acquired syphilis, it is in the tertiary period that lesions such as periostitis and exostosis are found in the labyrinth. The deafness is generally bilateral. Hereditary syphilis is one of the greatest enemies of the ears and is an important factor in the causes of deaf-mutism.

Where the deafness is due neither to traumatism nor syphilis, and it has become chronic, the best treatment is that of injections of pilocarpine. This substance favours the resorption of the exudation contained in the labyrinth by the intense sudation it provokes. Subcutaneous injections are generally preferred.

Hydrochl. of pilocarpine, 0.20 grammes;

Sterilised water, 10 grammes.

One drop corresponds to one milligr. of the active substance, and 15 drops should never be exceeded.

The patient will be given the injection, rolled in a flannel blanket. The injections should be given fasting, as besides sweating the drug produces nausea.

When the sweating ceases, the patient should dry himself thoroughly to avoid cold, and resume his ordinary occupation. The injections will be repeated every two days until a series of twelve have been given. If after this time no improvement is observed, the deafness is incurable.

When the deafness comes on gradually, sclerosis of the labyrinth is the cause, for which no treatment is of any account. However, as something must be prescribed, ten grains of iodide of potassium daily may be given for three weeks at a time.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, February 19th, 1905.

THE *Deutsch. med. Zeit.*, February 6th, contains a contribution by Dr. J. Lange on the

TREATMENT OF SCIATICA.

In twelve cases the following treatment was followed: At the point of exit of the nerve from the pelvis the skin was thoroughly disinfected and then, with a Schleich's syringe, a solution was injected into the nerve. This was to be lacerably simple, as it is a structure only $\frac{1}{4}$ cm. in width, and is always to be found in the same place. As the puncture through skin and

muscle was painless, the patient gave a prompt jump when the nerve in its sheath was touched by the needle. It was like an electric shock, and felt along the whole course of the nerve. This was looked upon as a sure sign that the nerve was touched. The pain was only momentary, as the solution followed immediately; 70 to 100 c.cm. were injected fairly rapidly. The puncture opening was then closed with sticking-plaster, and the patient was not allowed to lie on the side affected for some hours. Even during the injection the pain and tender pressure point disappeared, and after a time the patient complained only of a feeling of tension, which, however, passed off in the course of a few hours. The point of puncture remained painful a day or two. The solution employed was a 1 per cent. of β . eucaïne in an 8 per cent. solution of sodium chloride. Mild symptoms of intoxication had been observed, chiefly characterised by diminished appetite. In one case this lasted three days. Slight rise of temperature was also observed. The writer did not attribute any essential action to the eucaïne, but as it diminished the pain of the puncture it was as well to use it. He attributed the effect produced to compression and pulling on the nerve by the fluid, the action resembling that of nerve stretching. A cure was effected in six cases, in some, however, only after repeated injection. The effect was evident; one man, for example, who had suffered for four months and who could only limp along on crutches, was able to run forty-eight hours after injection. He recommended the method in obstinate cases.

At the Laryngological Society, Hr. Kutner spoke on the

INFLUENCE OF PREGNANCY ON TUBERCULOSIS OF THE LARYNX,

showing a case that was of interest, inasmuch as the patient was pregnant for a second time and the laryngeal disease was present during her first pregnancy also. She had then considerable difficulty in swallowing and hoarseness, which became less after the birth of the child. The left vocal cord was very red and had a cockscomb-like swelling in April last. Both cords were covered by a fold which gave one the impression of being the prolapsed mucous membrane of Morgagni's ventricle, the posterior wall of the larynx was infiltrated and ulcerated. In July she became pregnant again, and the condition got worse, so that the patient remarked that the hoarseness steadily increased. She was quite free from pain. In December she consulted the speaker. She was then voiceless, all parts of the larynx were infiltrated, and there was considerable dyspnoea. Then infiltration of the ary-epiglottic ligaments and cartilage and epiglottis came on. The general condition remained fairly good; there was no fever, no night-sweats, and only slight expectoration, grey in colour. There was not much lung mischief.

He looked upon the case as one showing the pernicious influence of pregnancy on the disease. The disease got worse visibly. On the other hand she showed exception to the rule that women generally succumbed to this disease after the birth of the child. As regarded treatment, there was the difficult question to decide whether abortion or premature labour should be induced. This decision depended on the state of the larynx and the stage of pregnancy. If the pregnancy was early and the changes in the larynx were not too far advanced, abortion should be induced.

In the discussion that took place, in which several members took part, doubts were raised as to whether interruption of the pregnancy would do any good. It must, however, be strongly emphasised that tuberculosis of the larynx, even if it had been cured, was a decided bar to marriage.

At the Society of Charité Physicians, Hr. von Leyden showed a case of

FRIGHT PARALYSIS

in a girl. æt. 16 , the disease taking on the type of a spinal paralysis. Psychological effects and long-lasting mental disturbances played a greater role in literature:

and in practice than in scientific medicine. Among the diseases which were attributed wholly or in part to psychical factors were chorea, Graves' disease, epilepsy, hysterical paralysis, paralysis of speech, and hemiplegias. The speaker mentioned several cases of fright paralysis from the time of the siege of Strasburg, which also corresponded to the spinal type of paralysis. Organic myelitis after psychic injuries had been observed by himself and Brieger. The real cause was not so much the first excitement as the subsequent recollection and brooding over it; one might assume a disposition to such diseases. The connection between jaundice, paralysis agitans, and psychical affections was of the same nature. In the case presented, sixty hours after the injury (fright from an attempt at house-breaking), there was paralysis of all the extremities and tactile and thermic anæsthesia and analgesia; the sensations of position and vibration were abolished. The prognosis was fairly good as the danger of organic disease was only slight. As regarded treatment, electricity and perhaps hypnotism were deserving of consideration.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, February 18th, 1906.

LACTIC SECRETION AND PREGNANCY.

At the Gesellschaft der Aerzte, Mandl gave his experiences in several cases of pregnancy to prove the practicability of Kreidl's experiments on animals. This subject has created a great deal of interest in the Society for some time past, and it was hoped that Kreidl's physiological demonstrations would have settled the question; but it seems that many are still sceptical of any good result that may follow. It should be remembered that a dispute arose about the function of separation of the placenta as the chief factor in stimulating the breasts to lactation; others contended that the death of the fœtus was the determining cause. Kreidl commenced operating on animals at different periods of pregnancy by performing laparotomy or destroying the fœtus *in utero*. In every case within two to four days after operation milk could be drawn from the breasts, from which he reasoned that the death of the fœtus was sufficient to stimulate the lactic glands. From this it was deduced that a practical diagnostic symptom had been discovered—that the presence of milk in the breasts during pregnancy was a definite assurance of the death of the fœtus. With these physiological facts before him Mandl now endeavoured to prove their utility by placing three cases before the members where the pregnancy was extra-uterine or tubal.

In the first case there was moderate hæmorrhage with intermittent colicky pains in the lower and left side of the abdomen; at the same time milk was emitted from the breasts. Laparotomy was performed and a typical form of tubal abortion was discovered.

In the second case, the hæmorrhage was not so great, but its constancy led to a dangerous state of the body. A microscopic examination was made of the secretion that could be drawn from the breasts, when the milk globules were found in great abundance. Laparotomy was performed, and a tubal mole was obtained, which he presented in a preserved form to the Society.

In the third case, the uterus was found to be enlarged on the left side, being soft and boggy in consistency. The patient suffered from cramps and pain in the lower part of the body, with intermittent hæmorrhagic discharges.

Milk could also be drawn from the breasts. From this he concluded that the case was a tubal abortion, and being so close to the uterus he adopted the expectant method of treatment. A few days later the lateral tumour suddenly disappeared, and ultimately became absorbed. The pregnancy in this case appears to have reached the tenth or twelfth week of duration. It would appear from these cases that the death of the embryo at an early period of pregnancy affects the milk secretion in the glands of the breast, which should not

be lost sight of as an important symptom in the diagnosis and treatment of the case.

Werth has set it down as a dogma that extra-uterine pregnancy should be operated on at once lest rupture of the membranes with hæmorrhage should take place; but it would seem that a dead embryo may disappear without any bad effects, and with an important symptom like the lacteal secretions, the attendant can confidently wait the recovery as was done in the second case. He does not consider the expulsion of the decidua from the uterus to be an uncertain proof of the death of the extra-uterine fœtus; but the milk secretion is a confirmatory diagnosis. The period that may elapse after the death of the fœtus varies according to different authorities, but two to four days are the recognised averages. Gessner records a case of tubal pregnancy in the third month which he operated on, and the milk did not appear in the breasts before the fifth day. He added that this proved to his mind that the death of the fœtus and not the placenta was the determining cause of the milk in the breasts. In the discussion that followed Halban denied that this was a new symptom, or that it could be recognised as diagnostic. Sinclair, Temesvary, and others had performed these experiments long ago, and recorded the same results. Observations in the human species had also been compared without arriving at any definite mode of operation. With Schauta's material at his disposal year after year, he had endeavoured to classify this abortive form of pregnancy, which he now divided into three. In the first form, the milk secretion appeared in the breasts on the first day; in the second form the milk secretion did not appear till after the discharge of the fœtus, even when weeks intervened between the death of the fœtus and its birth. The third form seemed to be evanescent, appearing shortly after the death of the fœtus, as a reactionary effect on the mamma, but a more definite effect was witnessed immediately after the birth of the fœtus. He was therefore inclined to adhere to the older view of the function of the placenta being the stimulating cause, and not the death of the fœtus only.

The Operating Theatres.

KING'S COLLEGE HOSPITAL.

POSTERIOR GASTRO-ENTEROSTOMY.—Mr. CARLESS operated on a male patient, æt. about 40, who for some months previously had been subject to pain coming on about an hour after taking food. This was followed by vomiting, but he had never shown any evidences of bleeding either in the vomit or the fæces. He complained of some tenderness, usually just to the left of the middle line, but occasionally more to the right, and always a little lower than the usual site of tenderness for a gastric ulcer. The stomach appeared to be slightly dilated, and the patient had lost weight. On palpation there was nothing in the shape of a lump to be felt, but there was some slight rigidity of the abdominal parietes. A test meal had been given, and the gastric juice showed a condition of hyperchlorhydria, with no lactic acid and no Oppler-Boas bacilli. Mr. Carless stated that in his opinion the case was one either of duodenal ulceration or of some contraction of the duodenum after ulceration. It was true, he said, that there had been no evident hæmorrhage, but it was quite possible to imagine duodenal ulceration without obvious hæmatemesis or melæna. Certainly the patient's general condition was rapidly deteriorating through the limitation of diet and the pain and vomiting associated with taking food, and it seemed quite clear that the reasonable practice to follow was to make an artificial communication between the stomach and the jejunum, whereby the

former organ might empty itself more rapidly without utilising the duodenum. He therefore proposed to do gastro-enterostomy, and, as was his invariable custom, to employ the posterior operation. An incision was made slightly to the left of the middle line, extending down to the umbilicus; the stomach and the upper part of the duodenum were found to be dilated, but there was no obvious evidence of ulceration, cicatrization, or new growth in spite of very thorough investigation both of the anterior and posterior surfaces. The omentum, and with it the transverse colon, were drawn up out of the abdomen so as to expose the under surface of the transverse meso-colon. An incision was then made through a non-vascular portion of this latter structure; through this opening the posterior wall of the stomach was protruded and the margins of the opening in the meso-colon were lightly stitched down to it. The upper part of the jejunum was next found and twisted over so that the surface which originally was anterior was made to look backwards, the result being, as Mr. Carless pointed out, that the same wave of peristalsis will carry the food out of the stomach and down the intestine practically in a continuous line. The jejunum was now clamped, and it and the stomach were approximated side by side by the hands of the house surgeon. A continuous catgut suture was introduced through the sero-muscular coats of the two organs for a distance of about two inches, and the free end was held by a pair of Spencer Wells' forceps whilst the further stages of the proceeding were carried out. An incision of a similar length was then made into the stomach and jejunum, running exactly parallel to this line of suture. A careful packing with gauze had been previously introduced beneath the approximated viscera so as to prevent soiling of the peritoneum, and a little bile-stained fluid, which escaped from the opening in the jejunum was mopped up with strips of gauze. The stomach had been carefully washed out with boric solution before the operation, and no fluid escaped from that organ. A second catgut suture was now employed to stitch the two layers of mucous membrane together; this, commencing on the left of the incisions, was carried continuously through the mucous membrane of the stomach and jejunum all the way round, the viscera being lifted up when the upper part of the incision was being dealt with. The loose end of the sero-muscular stitch was now picked up and the suture carried right round the junction, the stitches being introduced parallel to the margin of the wound according to the method described by Cushing, of Boston, as the right angle continuous suture; the apposition of the parts was so perfect that only one supporting stitch was required beyond the two main continuous sutures. The peritoneum was next cleansed, the parts returned, and the abdomen closed in the usual way. Mr. Carless commented on the gradual simplification of this operation, which had taken place during the last ten or fifteen years, and with it the decreasing mortality. As long as bone plates, bobbins, and buttons of different types and materials were employed the mortality, he said, was considerable; at the present time few surgeons employed any of these aids, but trusted simply to needle and thread, a deft pair of hands and suitable assistance; the last of these three, he thought, was all-important, as the assistant had much to do in suitably apposing the parts which were to be sutured together. The death-rate of gastro-

enterostomy was now, he remarked, something very small and the results of the posterior operation most satisfactory. Bilious vomiting was rarely troublesome, and the rapid emptying of the stomach was a most important element in the cure of many gastric and duodenal conditions.

It is satisfactory to state that this patient made a perfect recovery, and within a fortnight was eating fish, minced meat, and an ordinary diet without pain or discomfort and was only complaining of feeling hungry.

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The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, FEBRUARY 22, 1905.

THE TYPHOID EPIDEMIC AT LINCOLN.

ONCE again the familiar history is repeated of the terrible nemesis that waits upon the district that tolerates an ill-guarded water supply. The city of Lincoln is now in the grip of an outbreak of enteric fever that has seized upon all ranks of her citizens with a suddenness that is both appalling and dramatic. Briefly stated, by the end of last week there had been some seven hundred cases of typhoid fever in Lincoln, due to contaminated drinking water. The action of the Corporation in the matter of the water supply has been one of criminal carelessness. For the past twenty-two years they have had solemn and repeated warnings on all hands as to the polluted and dangerous state of the water supply of the town. The city authorities took over the waterworks in 1871, and the first alarm appears to have been raised in 1883, when attention was publicly drawn to the fact that the River Witham, one of their chief feeders, was so polluted as to render fishing impossible. In the same year the Medical Officer of Health reported to the Council on the wholly unsatisfactory state of the water supply. His report spoke of “considerable pollution,” and declared that the water was “so contaminated as to be unfit for domestic purposes,” and concluded by saying that “water from such a source is dangerous.” The reply from

the sapient Lincoln Council was that upon inquiry they found the water did not afford reasonable ground for complaint. Two years later the Local Government Board took the matter up, and formally intimated that the Council would "incur a grave responsibility if disease should hereafter spread in the city." In the following year an Inspector of the same Board drew the attention of the local authorities to "the unsatisfactory state of the water supply." These warnings, however, were disregarded by the Council, and in the year 1887 we find the Local Government Board once again insisting upon "the unsafe character of part of the water supply." The reply to this last representation by the Waterworks Committee was to the effect that they had the question under consideration. It was still before the Committee when later in the year the War Office condemned the water supplied to the barracks as unfit to drink, and a little later an outbreak of enteric fever occurred at the County Lunatic Asylum. Presumably the continuous consideration of a matter so vital to the citizens of Lincoln as the purity of their drinking water proved too great a task to be sustained by the Special Committee. At any rate, in 1892 we find a report from that body recording the grotesque conclusion that, although the quality of the water was not good, it was nevertheless sufficient in quantity. No suggestion was made, however, as to improving the quality. In 1892 the Local Government Board appear to have made their last formal remonstrance to the City Council. In 1894 the water was unhesitatingly condemned by the York Medical Officer of Health. The next leading event in this instructive history is the wholesale outbreak of typhoid fever in Lincoln early in the year 1905. There can be no doubt that the apathy and neglect of the Lincoln city authorities are wholly responsible for the economic loss attached to this deadly epidemic, not to mention the suffering, the subsequent ill-health and the loss of life thereby entailed upon its sufferers. Without pretending to any exact legal knowledge upon the point, it is conceivable that each individual sufferer may be entitled to full monetary compensation from a controlling sanitary authority that has so wantonly neglected its primary duties in the face of many years of solemn and repeated warning. Even now the Council does not appear to be grappling with the situation so as forthwith to ensure a supply of pure water. They have adopted some method of chemical disinfection, but their distrust of its efficacy has been abundantly proved by a public notice to the effect that no water from the mains must be considered safe unless it has been boiled for ten minutes. Under the circumstances, the Lincoln folk are certainly placed in a most difficult and perilous position. The need of an immediately purified water supply is so imperative that we venture to bring to their notice the only scientific plan which we believe to be capable of meeting their requirements. For some time past an

apparatus has been used widely throughout France generally as well as specially by the French military authorities for the instant sterilisation of water. The "Salvator" apparatus, as it is called, can be applied on any scale, so as to provide for a cottage, or, if need be, for a large town. It sterilises the water absolutely by means of heat, is almost instantaneous in action, and delivers the outgoing water at practically the same temperature as that of the inflow. This method has proved a boon to many unhealthy stations and districts in France, and is well worth the serious attention of the Lincoln citizens in their present strait. Sympathy with the sufferers, however, must not allow our indignation to be diverted from the culpable negligence of the City Council. The whole history of Lincoln and its water supply reads like a chapter from some chronicle of mediæval and pre-scientific days. It reveals, moreover, something of completeness lacking in the policy and the power of the Local Government Board in dealing with recalcitrant authorities.

PHYSICAL AND MENTAL DEVELOPMENT OF SCHOOL CHILDREN.

THE Conference on School Hygiene organised by the Royal Sanitary Institute, to which passing reference was made last week, was a gathering of much significance. Its avowed object was to prepare those who are interested in the subject for participation in the International Congress to be held the year after next, and to stimulate study of the problems connected with school life and training. The Conference was, within the limits to which it was necessarily confined, thoroughly successful both in point of attendance and of interest displayed. It may not be too much to hope that the practical conclusions at which it arrived will reach the proper quarters, and that they will tend to strengthen the hands of those who are striving to inculcate ideas of what we may call the "larger education." A great many causes, chief among which we may put the influence and teaching of medical men, have been in operation of late years to lift education, so-called, out of the rut of dull routine, and to give it an aim and scope that our grandfathers, and even our fathers, never dreamed of. The one idea that education consisted in introducing so much "knowledge" into the brain of the child, much as a joke is put into the head of the proverbial Scotsman, has fortunately given way to a more scientific system of mental training; and of still more recent growth is that yet broader conception of education that looks to it to enlarge not only the calibre of the mind, but to develop the muscles and framework of the body. The best definition of that much-defined word "education" is that which describes it as the adequate adaptation of the subject for a future environment, and it should be recognised that no mind can develop independently of its physical counterpart, or, at any rate, that it is highly undesirable

that it should do so. A proper balance between the training of both elements is indispensable to success; indeed, there is no reason why the two should be regarded as in any way distinct. The larger education would make them mutually complementary—intimate and essential parts of a homogeneous whole. The Conference just held will do something—we hope much—to strengthen this new bond, and to nurture the tender plant of scientific pedagogy that is struggling to pierce the clods of ignorance and prejudice that cumber the ground. The view was generally expressed—and one would have thought it would be self-evident to every clear-minded man—that the mental training of children cannot be cast in any Procrustean mould, but that the general principles which direct that training must be carefully adapted to individual circumstances, so that the less favoured physically and mentally shall derive benefit and not injury from their school work. The necessary corollary to this proposition is that a person skilled in the diagnosis of mental and bodily defects should have, if not entire charge of, at any rate a preponderating influence in, the apportioning of suitable curricula. In other words, a medical man of experience and skill should be a vital and organic part of the school staff, and, as the result of his inspections and examinations, the individual child should be dealt with. If this principle be carried to its logical issue it seems to us that a far more extended influence will have to be conceded to the doctor than is at present contemplated by even the warmest supporters of the cause. An occasional brief visit will never enable a medical man, however perspicacious, to decide in those questions, for each child must become an object of individual study, and his peculiarities and idiosyncrasies be thoroughly appraised, before a just verdict can be given. Moreover, his progress must be anxiously watched, and he must be re-examined and overhauled at short intervals. Such duties and functions carry the question to a point still further than that now contended for. They could only be satisfactorily carried out by men of considerable leisure, aptitude, and inclination, and in towns of any size to regard them as side-shows in the work of the medical officer of health would be to assure that they could never be satisfactorily accomplished. The medical officer of education should be as much an expert in his own province as a medical officer of health is in his, as the duties would be not a whit less technical and many-sided. Physical exercises were naturally much dwelt on at the Conference, and certainly not more than their importance warrants. The form that these exercises should take is still the subject of a good deal of difference of opinion, but we think that the right note was struck by Mr. Legge, the Inspector of Reformatories, in pointing out that these should be essentially recreations, and not mere mechanical performances to be gone through as so much drudgery. Though the mind should not be taxed during the execution of bodily exercises, it should not be

bored, and an element of exhilaration will alone call out the full powers of the muscles. It is by virtue of this stimulus that English games, such as football and cricket, make for finer physique than the monotonous evolutions of the German gymnasia, though the latter are in themselves better conceived as agents for developing the muscles. In this connection we are interested to note that the suggestions made some time back in these columns that Jiu-Jitsu—the Japanese national exercise—is coming more and more into evidence in this country. It seems, on the whole, better to combine the features of a good general form of exercise than any other.

Notes on Current Topics.

Selling of Practices.

THE buying and selling of practices is an unsatisfactory business at the best of times. The vendor who has, through his own energy and skill, built up a practice, finds himself, when he wishes to retire, with only that intangible asset—goodwill—to dispose of; and even when selling in the best of good faith, he cannot insure that all or any of the patients who come to him for advice will continue to do so to his successor. The purchaser, too, enters into a compact whereby he parts with a sum of money on the chance that the patients will like him as much as they have his predecessor. And of this no guarantee can, in the nature of things, be forthcoming till he is thoroughly settled in the vendor's stead, when it is too late to recant if he finds a falling off in his returns. It is not to be wondered at, therefore, that it not infrequently happens that doctors succeeding others think that they have been let-in in buying a practice, and that the law courts are sought to settle the matter. Much interest has been taken in the West of England in a case wherein one medical man brought an action to recover damages for fraud in connection with a Devonshire practice which he bought, and which turned out very differently from what he had expected. The vendor, from his admissions under cross-examination, appears to have been of a restless disposition, for he had spent much of his life in going from place to place in England gathering together a small practice and selling it after a few years to a new man. In the place in respect of which the action was brought, he was said by the purchaser to have represented that his practice was bringing in £800 a year, and the purchaser paid him £1,000 for the goodwill. In the result he found that instead of £800 he only earned £185 a year, and he attributed the fees shown in the defendant's books to be due to unnecessary visits and excessive charges. The defendant had an X-ray apparatus which he was asserted to have used in all sorts of cases, from cancer to deafness, and it was contended that employment of these rays in something like one-fifth of all patients attended was unjustifiable. The case lasted a long time, and eventually the jury found for the plaintiff and awarded him £200 damages. The story as

told in court was a painful one, well calculated to bring shame to those who hold the reputation of their profession dear. Perhaps the most regrettable part of the case is the disrepute brought on the X-rays as a therapeutic agent; like all other scientific methods of treatment they have their limitations, and it is sad to see them be-lauded as a sort of panacea, when such praise, in the long run, can only bring about disappointment and contempt.

The Misfortunes of the Central Midwives Board.

THE position into which that unfortunate body, the Central Midwives Board, has allowed itself to drift, owing to its repeated recognition of unsuitable institutions and persons as training centres and teachers of midwifery, has been very clearly brought home to it by Sir William Sinclair. During a discussion on the recognition of teachers and training schools, Sir William Sinclair said that he declined to discuss in detail the applications before the Board because the Board had recognised such unsatisfactory applicants as teachers of midwifery, and had approved such unsuitable institutions as midwifery training schools that he did not see on what principle any applicant for recognition as a teacher, or any application from any institution to be approved as a training school, could now be objected to. He could only look forward to the Board continuing its present policy, so that an unanswerable case would soon be made out for reconstitution of the Board by an amendment of the Midwives Act, 1902. In answer, the Chairman admitted, "in defence of the unfortunate Central Midwives Board," that perhaps, in spite of much care and trouble, the Board had made some mistakes. This is an important admission, but we are inclined to suggest that the number of these mistakes would have been very much fewer if those members of the Board who possessed experience and knowledge of obstetrical matters had taken a firm stand, had insisted upon their position as members of the medical profession, and had voted as such instead of either following blindly a lay majority or else refusing to vote. We re-echo Sir William Sinclair's hope. *Quos Deus vult perdere prius dementat*, and to endeavour in such a case to effect a cure would be a waste of time.

Fraudulent Companies for the Practice of Dentistry.

THE Irish Branch of the British Dental Association have during the past week won an important victory in their crusade against bogus dental companies. The Branch applied through the intermediary of the Attorney-General for an injunction to restrain a company, who carried on business as Mr. Appleton, Surgeon-Dentist, Limited, from taking or using such a name, or from advertising for custom under it or any other name or style containing the word "dentist," either alone or in combination with any other word or words or any name or title, addition or descrip-

tion calculated to lead the public to believe that the business was carried on by a person registered under the Dental Act of 1878. They also applied to restrain the directors or any other member of the company from allowing the company to remain registered under its present name. The defendants entered no appearance, and the Master of the Rolls, before whom the case was heard, granted the injunction with costs. This judgment is of so far-reaching importance that we are compelled by considerations of space merely to state the facts in a brief form. In our issue of next week we shall discuss at length the bearings of the judgment on the difficult question of bogus medical and dental companies. It must not be forgotten that, although at present it is the dental branch of the profession that suffers most from this particular form of fraud, if bogus companies succeed in carrying through their fraud, bogus medical and surgical companies in large numbers will inevitably appear in a short time.

Syphilis in Physicians.

THE necessity of counting syphilis as an "occupational disease" of physicians has recently been urged by Blaschko, who has had as patients no less than twelve medical men suffering from the disease. The primary lesion occurred in nearly every case about the hands, and was received in the course of gynæcological examination or operation. In some of the cases the cause of infection was the accidental wounding of the finger with an instrument, but in most it occurred through some unnoticed scratch or minute lesion. In one case, indeed, infection was definitely traced to the performance of an autopsy in a syphilitic case. The primary lesion was usually very small, and by no means painful, and presented some difficulty in diagnosis; in particular it had to be distinguished from herpes, from anatomical tubercle, and from chancroid. Blaschko advises against excessive use of the scrubbing-brush in preparation for gynæcological examination, as he thinks it is responsible for many slight traumata about the fingers. He advises, too, and we cordially agree with him, the more frequent use of gloves in general gynæcological work.

Anthrax.

IT is disquieting to read from several widely-distant parts of the country that cases of anthrax are occurring from time to time. The Home Office rules for the protection of workers engaged in wool-sorting, washing, and combing have done much to lessen the risk attached to those occupations, but there are still loop-holes in the defensive armour, and while such is the case anthrax is bound to show itself from time to time. A case illustrating one of these defects was brought to notice at an inquest at Bradford recently. The deceased man was a wool warehouseman, and his duties consisted in packing "tops and nails" in sheets and bales, a part of the business that was not considered dangerous as the wool had

already undergone several processes of washing and drying before coming to the packers. The man, however, had a scratch on his wrist, and one day felt a pricking sensation in it; presently a pimple was noticed to form. Thinking, however, that his blood was merely "out of order," he did not place himself under medical treatment, and when he finally did so general blood infection had set in, and in spite of serum treatment he died in two days. We are glad to notice that the Home Office inspector who was present at the inquest was able to say that new rules were being prepared, and that Persian wool—the variety the deceased man was handling at the time of the accident—was to be severely hedged about with restrictions, but no rules can possibly be devised to protect workers completely without their active co-operation. One of the greatest difficulties in the administration of the Factory Acts is the carelessness and negligence of the workers with regard to their own welfare, and while this is so it is impossible to make sure that fatal accidents of the kind mentioned will not occur.

Longevity and Brain-work.

A GREAT deal of weight is attached to over-work and over-strain as a cause of early death, and there is constantly an increasing tendency to put down premature decease to these causes. It is doubtful, however, if mere over-work—that is to say, hard brain-work—is so widespread and potent a factor in causing early mortality as it is fashionable just now to make it. Over-strain, on the other hand, is another matter. A man of average constitution can persistently maintain a high level of intellectual toil for many years without damage, and even with benefit, if his home is free from cares and his surroundings moderately hygienic. The early breakdowns and premature deaths of many well-constituted men is due to burning the candle at both ends; a day of toil in the office or factory and a night of broken rest through ill-health or anxiety at home. We have only to look at the green old age which crowns the labours of most of our prominent politicians, whose lives are spent in a round of unremitting toil, to see that intellectual labour under severely trying conditions is quite compatible with excellent health and longevity. The converse, however, cannot be stated so emphatically. A medical witness in a recent High Court action expressed the opinion that "brain-softening" with early death was a very common occurrence in agricultural labourers, and that this was due to want of mental exercise. The intellect of the rural labourer "rusted out." Judges, he said, and others whose thinking capacities were greatly employed, invariably lived to an age far beyond that of the average rural labourer—provided, of course, they lived consistently. We are not surprised to read that the learned judge and his brethren of the Bar received this opinion with smiles of satisfaction, but, for our own part, while assuring them that there is no *prima facie* reason

why they should not last well into their second childhood, we cannot take so pessimistic a view of the prospects of the rural labourers. A sane mind in a healthy body is doubtless the ideal, but it is wonderful how well the animal functions can be performed in a body that owes but little to the control of the higher brain levels.

The Serum-Therapy of Tubercle.

DURING the past twelve months the method of serum treatment for tubercle most prominently before the profession has been that put forward by Marmorek. He held the view that tuberculin was not itself the toxin of tubercle, but that it was a bacterial product which served to excite tubercle bacilli to the production of a toxin. This being so, one could not expect any satisfactory result from treatment by anti-tuberculin serum. By the growth, however, of tubercle bacilli in a special medium, "leucotoxic serum," whose preparation is very complicated, he has been able to produce a toxin which causes definite lesions in horses and other animals. To this toxin an antitoxin is produced in the blood of horses. It will be remembered that when Marmorek published his investigations a year ago, they met with hostile criticism from many French observers. The later reports, however, both in England and Germany, have been more favourable. Latham, Richer, and Fry all think well of the action of the serum, and advise further trial. More recently Friedman has separated a culture of tubercle bacilli from the lung of a turtle, and this culture is so innocuous to higher animals as to be available as a vaccine. In addition, it causes so high a degree of immunity in the ox that the serum of the latter may be used as an anti-serum. No trials have yet been made in the human subject, but the prospects are most promising.

The Russian Giant.

MACHNOW, the Russian giant, who is now on exhibition in London, is a phenomenon that will have a special interest for medical men. It is claimed on his behalf—and with apparent justice—that he is the biggest man alive, and he is probably the tallest man of whom authentic record exists. Although only twenty-three years of age, his height in his socks is 9 feet 8 inches, and he is built in proportion to his altitude. Thus his hand is 1 foot 7 inches from finger tip to wrist, his foot is 2 feet long, his chest measurement is 60 inches, the circumference of his head 27 inches, and his weight 32 stone. To support this huge frame he eats an amount that rivals that of the fabulous contemporary of Jack-and-the-Bean-stalk. In four meals in the course of the day he gets through two dozen eggs, three to five pounds of meat, three or four loaves of bread, large quantities of potatoes and vegetables, three quarts of beer, and some three quarts of milk and tea. These quantities appear to be well attested, as do the measurements of his proportions, but the fact that arrests attention particularly in the accounts of the giant's habits is the enormous amount of

sleep that he needs. Normally he passes a large portion of the day in slumber, and he has been known to sleep for twenty-four hours on end. Even when awake his movements are slow and deliberate, and he is inclined to doze off when left alone, the only stimulus to exertion being the cravings of hunger, which are said to be very acute. It is impossible in the light of recent researches on giantism to regard this prodigious specimen of humanity as a mere "freak." He must be the subject of pathological change, probably in the pituitary body. The condition of general symmetrical giantism gradually developing is not on all fours with true Marie's malady, but it is closely allied to it. The prognosis with regard to longevity of the subject cannot be said to be a very bright one.

Clinical Examination of Saliva.

It is somewhat curious that of all the excretions the only one which we are in the habit of examining systematically is the urine. This is doubtless due to the ease with which we can obtain it, and the large quantity which is excreted. It is of interest, however, to ask in how far the changes from the normal undergone by urine are parallel to those that take place in the other excretions. Dr. Lederer, of New York, has examined the saliva in a number of pathological conditions, and his observations have been published. (a) Recognising the difficulty of obtaining saliva as it flows from one of the glands, he has contented himself with the mixed fluid as found in the mouth. He examined a large number of cases of diabetes, and in 85 out of 158 glucose was found to be present. Dr. Lederer is of opinion, too, that in more than half the cases of diabetes there was a diminution of the amount of saliva secreted; this is obviously, however, a difficult matter to test with anything like accuracy, as the rate of secretion of saliva is so easily altered. In 90 per cent. of the cases there was no alteration in the amylolytic action of the saliva. In a number of cases of "uricacidæmia," uric acid was found excreted by the saliva. Bile pigment was looked for on several occasions, but only discovered once. According to Lederer's observations acidity of the saliva is by no means uncommon, as he found it in many different conditions—diabetes, acute gastritis, hyperchlorhydria, and pyloric stenosis.

Euphagia.

THE dreadful consequences that may ensue when insufficient time is given to the process to mastication are familiar to every first year's student of medicine. Lecturers in physiology always take care to impress upon their hearers the importance of the first digestive process, that of insalivation, which should on no account be hurried over. Due preparation cannot, of course, be given to the food in the mouth when "the grinders are few," and every physician has met with severe and chronic forms of dyspepsia which have been completely cured by a visit to

the dentist, who has fitted a suitable set of false teeth. Even if the dentition be perfect, the food may be bolted, or the surroundings unfavourable to the proper and leisurely consumption of a meal. This ideal process is termed "euphagia" by Professor Max Einhorn, (a) who is a strong believer in the influence of the mental state upon digestion, the importance of which has also been shown by Pawlow. Cheerful company, appropriate music, and pleasant conversation go a long way towards the enjoyability of a meal, and there is a physiological reason why this should be so. It is commonly said that those who eat quickly are quick in everything else, but the converse is certainly not the case. The habit of eating too slowly, known as bradyphagia, is more rarely seen, but it occasionally occurs to such an extent as to constitute a veritable morbid state. Particles of food are vigorously masticated and re-masticated until it would seem that the individual is actually afraid to swallow. The condition which has been described as sitophobia may ensue in some cases. Neurasthenics are particularly liable to err in this direction, and such should be made to finish their meals at the same time as others, provided, of course, that there is no physical impediment to their doing so.

Instruction in Domestic Hygiene.

THE starting-point of hygiene, like that of charity, should be at home. If the principles of healthy living are to take root in the heart of the nation they must first be taught by the fire-side and in the kitchen. Educational authorities are, happily, beginning to realise what an immense influence they can exert in this direction upon the minds of the young. The observance of the laws of health does not come naturally any more than does the love of books, and, indeed, men are apt to be afraid of both, unless they have been accustomed to them from their infancy. It is a wise and prudent step, therefore, to sow early the seeds of the knowledge of hygiene, and especially to display it in an interesting and a practical fashion. The provision of an ideal schoolroom from the sanitary point of view is one thing, and the visual demonstration of the poisonous properties of carbonic acid, simply illustrated so as to be readily grasped by the mind of every scholar, is quite another. That some useful work is already being done by the London County Council in this direction is shown by the interesting exhibition of work done by the scholars of the Public Elementary and Evening Continuation Schools in the Boroughs of Bethnal Green and Stepney now on view at the Whitechapel Art Gallery. Comfortable cradles are shown simply made out of ordinary clothes-baskets, and if these are not obtainable, the elder girls are taught how to make hammock beds out of sacking and rope. The teaching of housewifery, thus imparted, cannot fail to be of the greatest benefit to the inhabitants of the crowded districts in the East

(a) *Journ. of the Amer. Med. Assoc.*, December 10th, 1904.

(a) *Medical Record*, January 7th, 1905.

End of London, and we note also that considerable stress is laid upon the feeding and general management of infants, cards of instruction being issued upon this most important subject.

Copper as a Disinfectant.

SOME of the American dailies have been devoting much attention to the use of copper sulphate for the destruction of typhoid bacilli. It is claimed that by simply adding small quantities of sulphate of copper to a polluted drinking water, the bacilli are speedily killed, and all danger from the water is at an end. As a matter of fact, the basis for such extravagant statements is a series of laboratory experiments undertaken by Dr. Edward Martin, the Director of Public Health in Philadelphia. He finds that a very slight trace of copper in water is sufficient in a few hours to destroy any typhoid bacteria that may be present. For instance, if water containing typhoid bacilli be allowed to remain in a copper vessel for three hours, it is said that enough copper will have been taken up to render the water sterile. It is, of course, much too early in the course of Dr. Martin's investigations to come to any conclusions as to the possibility of making use of this property of copper on a large scale, though he at present thinks the prospect hopeful. In the meantime the question is raised as to whether copper is itself a safe constituent of drinking water. For long it has been held that there is grave danger in the use of copper utensils for cooking and such purposes, but we confess that the evidence in favour of this tradition is but slight. It is improbable that the small quantity of copper required, according to Dr. Martin, for the destruction of typhoid bacilli would have any injurious effect on the human organism.

An Historic Autopsy.

To a recent number of *American Medicine* Dr. Andrew Smith, of New York, contributes an interesting account of the *post-mortem* examination made by him nearly a quarter of a century ago on the body of President Garfield. Garfield had been shot in the abdomen early in July, 1881, but did not die till September 20th, having shown during the intervening months symptoms of pyæmia. The surgeons, by examination of the wound with a flexible probe, had formed the opinion that the bullet was lodged in the right iliac fossa, and this conclusion had been confirmed by Dr. Graham Bell's ingenious "induction balance." Accordingly, when the autopsy was begun it was agreed to remove the hollow viscera before beginning the search for the ball. To everyone's surprise, no fistulous path was to be found in the iliac fossa, and it was only after prolonged search in that region that it was noticed that several of the vertebræ were covered with a dense exudate. On removal of this it was found that the bullet had entirely pierced the first lumbar vertebræ, passing obliquely from right to left. It was finally found encysted close to the tail of the pancreas, and it had been removed and thrown aside with the viscera. In its passage

it had carried splinters of bone in its path, and had set up a line of abscesses. In addition, it had grazed the splenic artery, causing an aneurysm, the rupture of which was the immediate cause of death. Dr. Smith does not think that, even with the use of the X-rays and modern methods of treatment, any other result than death could have followed the wound received by President Garfield.

PERSONAL

SIR FRANCIS LAKING and Sir Frederick Treves last week received Queen Alexandra, attended by Lady Suffolk and the Hon. Charlotte Knollys, who paid an informal visit to the Royal College of Surgeons, Lincoln's Inn Fields.

MR. EDGAR SCHUSTER, of New College, Oxford, has been appointed to the Francis Galton Research Fellowship in national eugenics.

THE Charter Day dinner of the Royal College of Surgeons, Ireland, which was to have taken place on Saturday evening, February 11th, was postponed owing to the illness of his Excellency the Lord Lieutenant, who had accepted an invitation to be present. The new date has been fixed for the 25th inst. We understand that the annual dinner of the Leinster Branch of the British Medical Association, which was to have taken place on that date, has consequently been unavoidably postponed.

THE following have been elected members of the Board of Faculty of Medicine, Oxford, and will hold office until February, 1907: Sir William Selby Church, Bart., M.D., Christ Church, Honorary Fellow of University College; Walter Ramsden, D.M., Fellow of Pembroke College; Ernest William Ainley Walker, D.M., Fellow of University College; Walter William Fisher, M.A., Corpus Christi College; Samuel Hatch West, D.M., Christ Church; William Bruce Clarke, B.M., Pembroke College.

THE annual meeting of the Leinster Branch of the British Medical Association will be held in the Royal College of Physicians, Dublin, on February 25th, when the incoming President, Sir Thomas Myles, will deliver an address.

MR. W. H. CURTIN, local sanitary inspector at Lincoln, has fallen a victim to typhoid fever. He worked heroically but unsuccessfully to stamp out the epidemic before it gained a hold.

THREE candidates have been selected for the Clerkship of St. Bartholomew's Hospital: Mr. A. J. Austin, secretary of the City of London School; Mr. T. Hayes, secretary of the East London Hospital for Children at Shadwell; and Mr. J. M. de Vine, secretary of the National Hospital for Consumption, Ventnor. The governors of the hospital will elect one of these at their Court Meeting on the 23rd inst.

THE Council of the University of Leeds have appointed Dr. J. Spottiswoode Cameron (the City Medical Officer of Health) as Professor in Public Health, and Dr. Porter (his assistant) as honorary demonstrator in the same subject, in the School of Medicine. At the same time Dr. Trevelyan was appointed Lecturer in *Materia Medica* and *Pharmacology*.

MR. MALCOLM MORRIS will deliver the Harveian Lecture on "Some Modern Therapeutic Methods in Dermatology; with Exhibition of Cases Treated by the X- and Finsen-rays," on March 9th, at 8.30 p.m., at the Stafford Rooms, Titchborne Street, Edgware Road, London.

PROFESSOR SYMINGTON, of Queen's College, Belfast, has been appointed an Examiner in Anatomy in Trinity

College, Dublin. Professor O'Sullivan and Dr. Henry Jellett have been re-appointed respectively Examiners in Pathology and in Obstetrics and Gynæcology in the Royal University of Ireland.

DR. A. R. CUSHNEY, of the University of Michigan, has been appointed to the chair of Pharmacology at University College, London.

THE council at University College Hospital, London, have passed resolutions of regret on the resignation of Professors F. T. Roberts and Vernon Harcourt.

THE ASSOCIATION OF MEDICAL DIPLOMATES OF SCOTLAND—INAUGURAL DINNER,

FEBRUARY 14th, 1905.

LAST Tuesday some fifty-eight guests, representative of the above Society, gathered at the Trocadero for their inaugural dinner. Mr. Claude St. Aubyn Farrer, L.R.C.P.&S.Ed., President, occupied the chair. Among those present were Sir J. Andrew Clarke, Sir John Tyler, Colonel Anderson, I.M.S., Brigade Surgeon Lieut.-Colonel E. J. Hunter, Drs. Fitzgerald Powell, Skene Keith, Lewis (St. Leonards), Outterson Wood, Parsons, C. O. Hawthorne, James Rutherford (Harrogate), Euphemia Stoker, F. J. Waldo, Messrs. Heather Bigg, Noble Smith, Milson Rees, Chisholm Williams, Richard Greene (Lewes), S. Lightfoot (Watford), F. E. Fenton, and others; Dr. David Walsh (Hon. Sec.) and Mr. William Bell (Hon. Treasurer).

The President, in his speech, explained that there was a large and increasing number of Scotch diplomates practising in England, Ireland and Wales out of touch with their own colleges and with one another, and the present Association was created to advance the interests of Scotch diplomates in every way; to let them air their grievances, one of which—having gone on for 300 years without a distinctive licentiate gown—was already remedied, for at that moment he and Dr. David Walsh (Hon. Sec.), and Dr. Euphemia Stoker, the first lady to join their Association, were wearing the very gowns asked for. There had been difficulties at the beginning, but members were rapidly joining. When he had gone up to Edinburgh, men like Sir Patrick Heron Watson and Sir John Halliday Croom and Sir Alfred Cooper had readily consented to become Vice-Presidents of the new Association. It was clear that any single individual, however strong and energetic, could do little or nothing by himself; but, an association got together, great things were possible. At future meetings consultants and specialists would meet general practitioners, and mutual good would undoubtedly ensue. He had no idea until the Association was formed that Scotch diplomates had so many grievances; but the Council were glad to have an opportunity of knowing them, and had determined to try and remedy the greatest of all, namely, their present position with regard to London hospitals. Moreover, for the convenience of members, districts would be grouped, so that each member would know if any of the Association lived near him.

Dr. David Walsh (Hon. Sec.), replying for the Association, referred to the great debt of the Association to their former hon. secretary, Mr. Heather Bigg. He remarked on the fact that they were having their inaugural dinner early in the year of the tercentenary of the Royal College of Surgeons, Edinburgh. That coincidence he could not but regard as an omen of the happiest augury. He hoped with the President that the objects for which the Association had been formed would be carried out, especially that of bringing medical men living in one district in touch with one another. In that way the Association of Scotch Diplomates might be laying the foundation of a real and universal organisation in the ranks of the medical profession. Only the other day he had had a letter from one of their Council asking whether there was in Croydon any member of the Association to whom he could send a patient. One other reform demanded by

many diplomates was the substitution of "Member" for the title of "Licentiate" of the Royal Colleges of Surgeons and Physicians. In this he echoed the opinion of all Licentiates, although they were faced with the initial difficulty with regard to the formal title of "Doctor," that a Licentiate did not hold a degree but he thought some compromise would probably be arrived at. Their position with regard to the well-nigh universal exclusion from London hospitals was extraordinary when one reflected on the number of men with Scotch qualifications whose work was even to-day benefiting hospital patients in London, and, indeed, so far as that went, all over the world. Who did not remember the late Dr. McLagan and the world-wide boon he conferred upon humanity by the introduction of salicylates in the treatment of rheumatism; Donald Ross and his researches into tropical disease; Simpson and chloroform; Lister and aseptic surgery? yet the men coming from schools that could boast such names were excluded from the majority of honorary hospital appointments in London, and from a smaller number in the provinces. Such unfair regulations he hoped and believed could not exist much longer if their Association and its indefatigable President did all the work they anticipated.

Mr. Noble Smith proposed "The Army, Navy, and Volunteers," in a brief but pointed speech.

Sir J. Andrew Clarke, replying for the Army, said there was one point in the Army Medical Corps he would like to notice—that in times of war outside medical civilian help had to be sought in spite of the efficient help rendered by the Red Cross Brigade. He would have the Army Corps organised in times of peace so effectually that when war came everything of the medical service would be strong enough for the demands put upon it.

Colonel Anderson, I.M.S., and Brigade Surgeon Lieut.-Colonel Hunter, V.M.B., also responded.

Dr. Hawthorne proposed "The Council and Officers of the Association."

Mr. Sidney Stephenson, in response, said they were an Association with many objects. Nothing that was popular among the members would be uncatered for by the Council, and he hoped the disabilities under which Licentiates had hitherto worked in England would speedily be rectified. Dr. St. Aubyn Farrer was an indefatigable President, and had given up the whole of his spare time to promoting the interests of the Association.

Dr. Euphemia Stoker (who wore the handsome new gown of the R.C.S. of Edinburgh) replied on behalf of the lady members of the Association, who were six in number. The lady doctors had all felt honoured by being admitted members of the Association, and she hoped to see them one day on the Council.

Dr. Fitzgerald Powell proposed the toast of the visitors, which was responded to by Dr. Snape, Dr. F. J. Waldo and others.

Some excellent songs were given by Miss Eugénie Neilson, Miss Amy Brook, Mr. Frank Moody, and Mr. Margetson.

[Society of Apothecaries of London.

Surgery.—H. H. R. Bayley (Section II.), A. Beeley (Section I.), J. A. Davies (Section I.), L. Sells (Section I.), R. W. Taylor (Sections I. and II.), I. C. Thorburn (Section I.), P. L. Vawdrey (Section I.).

Medicine.—A. Beeley (Sections I. and II.), J. B. Bradley (Section II.).

Forensic Medicine.—A. Beeley, H. A. Browning, C. F. Kernot, P. C. W. Laws, W. A. T. Lloyd, J. A. R. Wells.

Midwifery.—A. Beeley, A. J. K. Brayton, O. P. N. Pearn, I. C. Thorburn, J. H. Wolfe.

The Diploma of the Society has been granted to the following candidates, entitling them to practise Medicine, Surgery, and Midwifery:—H. H. R. Bayley, R. W. Taylor, and J. H. Wolfe.

Special Articles.

SURGEON-GENERAL EVATT'S REPORT ON THE

IRISH MEDICAL ASSOCIATION.

As Special Commissioner on behalf of the *British Medical Journal*, Surgeon-General Evatt, C.B., early in 1904 crowned a visit to Ireland with a report on its Poor-law medical service, which classed him at once as a powerful and imaginative writer. A suggestion contained in that report was that the medical profession required better organisation than then obtained, and so, in order to carry this into effect, arrangements were made last autumn between Surgeon-General Evatt and the Irish Medical Association by which he was to report on a scheme for reorganisation of the Association, and to indicate whether any changes were desirable in the much-discussed Mayo-Enniskillen resolution. It is possible that such a report as this might well have been written by the General in the quiet of his study without again going over the ground that he had already covered in Ireland, and without depriving the badly paid Poor-law medical officers of the several hundreds of pounds which they so readily subscribed for his payment. However, he decided to visit Ireland. He was brought over to speak to an Inaugural Address in St. Vincent's Hospital before any arrangements had been made for his reception in the provinces; several places such as Waterford, Limerick, and Sligo did receive him, but, particularly in the North, the time for such an invasion was considered inopportune and the services of the General were dispensed with.

During his campaign in the West, reports of various kinds were set in circulation concerning him. One of them credited him with using his platform to promulgate Home Rule doctrines, another gave him credit for denouncing the incapacity of the Dublin teachers of medicine and surgery and the inefficiency of the medical schools.

The appearance of his report was therefore looked forward to with interest, and also, perhaps, with some misgivings. When in due course it reached the secretary of the Irish Medical Association, copies marked "Confidential" were sent to every member of the Council, and its consideration was fixed for Wednesday, 15th inst. We understand that at this meeting the report was referred to a sub-committee on the understanding that it should not be divulged to the Press until the Council had again met to consider the recommendations of the sub-committee in regard to its adoption and publication. On the following morning, however, the Editor of one of the Dublin daily papers announced that a correspondent had favoured him with a copy of the report, and a few carefully selected and spicy extracts were given in which the writer had passed serious strictures on the two Irish Colleges of Physicians and Surgeons. These two bodies are accused of having treated their Licentiatees with neglect and want of sympathy, and at their doors Surgeon-General Evatt places the blame for the condition into which the Irish profession of medicine has been allowed to fall. Perhaps if the I.M.A. were again to employ Surgeon-General Evatt, he will first ascertain what proportion of the medical practitioners in Ireland hold their qualifications from the Irish Colleges. Supposing he then finds that this amounts to even one-third of the total number, will he annihilate with his pen the two universities and the Scotch bodies who are responsible for manufacturing the remaining two-thirds because these bodies do not provide clubs and afternoon tea for their graduates? It is highly probable that the Colleges may have to take action to defend their reputation from charges which are not only libellous, but misleading and without foundation. Surgeon-General Evatt says: "If ignorance and drunkenness are to-day doing a distinct damage to Irish medicine, the eternal blame for them will rest on the cliques that figure before the

world as the Royal College of Surgeons and Royal College of Physicians in Ireland." Wild talk of this kind can only injure the I.M.A., and that to a very vital degree. The College of Surgeons has housed the Association for many years, and it is almost past belief that a gentleman, who presumably must be a member of the Council of the I.M.A., and who has been enjoying the hospitality of the College, should hand over to the Press a confidential document which contains untrue and libellous statements regarding that College.

Surgeon-General Evatt's remarks concerning the Dublin consultants who accept titular honours while their dispensary brothers are perishing in the country are so singularly wanting in taste, and have so little to do with the reorganisation of the I.M.A., that their introduction can only lead to estrangement and mischief in the profession. Only a dreamer of the most irrational dreams could state, as is now stated by Surgeon-General Evatt that "the I.M.A. ought and must become an important national faculty of Medicine to be the controlling force over the medical profession in Ireland." Surgeon-General Evatt, who is a Licentiate of the Royal College of Surgeons, did not at any time think it necessary to present himself for the Fellowship Examination of this College, although this is just what a good proportion of the Licentiatees of the College do. It is one of the means by which their scientific efficiency is maintained. To obtain the Fellowship requires from them money, time, and study; and if there are Licentiatees of the College like Surgeon-General Evatt himself who are content to ignore, or unwilling through laziness to seek for, higher qualification within their reach surely the College is not to be blamed in the matter. Surgeon-General Evatt is dissatisfied with the mode of election by co-option to the Fellowship of the Royal College of Physicians. It is the same method by which Fellows are elected in the London and Edinburgh Colleges of Physicians. In the case all three Colleges there is a membership examination, which takes the place of the Fellowship Examination in College of Surgeons, and it will probably be some time before the Charter of the College of Physicians is so altered that a man may be admitted to its Fellowship without any regard to his professional attainments and worth other than those disclosed by examination. He is pleased to refer to the Fellows of the College of Physicians as a narrow, bigoted clique. Bigotry is an unpleasant and an ambiguous term. Will Surgeon-General Evatt particularise? Finally, we regret that this unwarrantable attack should have been made on the Irish Colleges by an Irishman, and that another Irishman should have been found capable of handing over a confidential document to the public Press, by which only a few extracts most injurious to the interests of the I.M.A. were printed and to the discussion of which we have been compelled to confine our remarks. Doubtless much that is good will be found in the remainder of this report, and many suggestions that may help to restore the prestige of the Irish Medical Association. It is unfortunate that the gentleman who violated the confidential character of the report only did so to an extent that is calculated to injure the Association, and that he did not also publish that part which deals with its present constitution. It is equally unfortunate that Surgeon-General Evatt has apparently exceeded his instructions.

If he had been content to carry out whatever loosely expressed instructions he received in regard to a suggested scheme for the reorganisation of the Association, subscribers might have felt that they had received some value for their money, but now we fear that the outcome of the whole conception must be material injury to the Irish Medical Association.

Trinity College, Dublin—Hilary Term, 1905.

Final Examination in Medicine—Section B. :—
William F. Samuels; Madeleine S. Baker, William C. MacFetridge, John H. Waterhouse, equal; Thomas T. H. Robinson, George S. Walton, Cyril H. M'Comas, Edward D. Atwell, Cecil A. Boyd, John B. B. Whelans.

Correspondence.

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

CYSTIC ENDOMETRITIS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In the interesting communication by my friend, Dr. Purefoy, in your last issue, the following occurs:—

"In cystic, as in every other form of endometritis, the first and perhaps the most important indication to be fulfilled in treatment is to secure a sufficiently patulous condition of the cervical canal to admit of free escape of healthy and unhealthy discharges."

Dr. Purefoy does not tell us how this is to be carried out. My own plan for years past has been to introduce my hollow spiral wire stem open from end to end to be worn after curetting, especially so as to ensure a patulous canal for sufficient time to effect a cure. The mere dilatation and curetting I have found long since quite inefficient, and have been amused at the efforts made to drain the uterus by iodoform gauze (or, indeed any kind of gauze). How any viscid discharge can possibly find its way through gauze I fail to see? the gauze acting more often as a plug than a drain, obstructing instead of aiding the exit of secretions. Ordinary cases of endometritis can be cured by *free drainage alone*, if the drainage-tube be worn long enough, which, of course, will depend on the severity of the complaint and the judgment of the gynaecologist. Dr. Purefoy has kindly alluded to my uterine applicator and curette combined, which will, I imagine, if used supply the want he alludes to, *viz.*, a safe applicator.

I am, Sir, yours truly,

ALEXANDER DUKE.

THE CLASSICAL SYSTEM IN OUR PUBLIC SCHOOLS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It would be well if some of us took an interest in the question of what we think our boys should be taught at school, when we look forward to their lives being spent in the practice of our profession. Many years ago—that is, in our fathers' and grandfathers' times—the public schools were regarded as confined to the education of boys intended for one of the professions—the church, the law, or medicine. Our universities were the same, except that some young men of wealth or rank, who were never going to work for a living, went up to them, so that they might enter into political life with certain knowledge and tastes that the best of the aristocracy of this country consider necessary for the upholding of the character of a great family. The Church naturally looked to the study of the Classics and the religious literature of the past as the best preparation for those that were going to be the teachers of religion. The lawyers, too, were obliged to know something of the Latin tongue, as the whole system of our laws is based on Roman legislature. As for the doctors, there was a feeling that in the writings of the Greek and Roman authors were to be found the best types of careful and accurate observation of the symptoms, treatment, and characters of disease.

The ancients had handed on to us a reverence for the profession based on the spirit in which it was followed, and the years of study expected to be devoted to it.

Things have changed during the past fifty years. The College of Physicians gave up its Harveian Oration being in Latin; and now our prescriptions may be written in the vulgar tongue. There are only a few left now who hold the views of their grandfathers on this question of education, and the leaders of them are headmasters of some of our great public schools. They have not been pleased to see the changes and have opposed those introductions of the teaching of science which now in some of our schools and universities takes precedence of the Classics.

Of course, one of the chief obstacles to this teaching of science was removed when headmasterships were

not confined to the Church. The idea that we were wise in trusting our boys to men of religion was natural, but we have gradually learnt that true religion is to be found among the leaders of science in this and other countries in as high, if not more unselfish and admirable a spirit, as among the professors of religion.

The members of the medical profession have been naturally inclined to the study of science, and the dogmas and creeds of religion have not found great support among them. To come to the simple question what kind of education is the best to make a boy a good doctor, it should be carefully considered by all those who have sons preparing for the profession. If a boy grows up, and finds that his father has foolishly entrusted to the schoolmaster a matter that he ought himself to have directed and controlled, and that the mistakes made in the very important work of training have brought troubles later in life which could easily have been avoided, those feelings of respect which should exist between parents and children must be disturbed, and instead of reverence and esteem, little but contempt can fairly be expected to remain. A boy brought up with the idea that he cannot be a gentleman unless classically educated, and that the money spent on a public school and university is capital invested in the safest way to secure him provision in professional life, will be sadly disappointed. If left without means, and possibly expected by his parents to support himself when his training has ended, he may find that he is thrown out into the world, and is really worse off than the son of a poor working man; for he is like a thoroughbred horse being put to the plough. What mistakes parents may make are well seen in our Colonies, for there is nothing left for some but to disappear from the old country and begin anew. Let us not be misled now by such men as Dr. Warre and others in the education of boys for the medical profession. There is a great deal still to be done to make the present system satisfactory, for the cramming for examinations is bad; and there is a tendency among the boys to avoid the steady practical work which they look down upon with a kind of contempt as beneath them and unworthy of attention.

I am, Sir, yours truly,

R. L.

Obituary.

DR. CHARLES HERBERT GAGE-BROWN, M.D.

DR. CHARLES HERBERT GAGE-BROWN, M.D., died at Cadogan Place, S.W., on Tuesday last from pneumonia, after only a few days' illness, at the early age of 45. He was the eldest son of Sir Charles Gage-Brown, K.C.M.G., was professionally educated at the University of Edinburgh, and at the medical school of Middlesex Hospital, and had held the appointment of clinical assistant at the Central London Throat and Ear Hospital, in the electro-therapeutic department of St. Mary's Hospital, at the Hospital for Children in Great Ormond Street, and at St. Luke's Hospital.

FLEET-SURGEON DONALD MACIVER, M.D.

WE regret to record the death of Fleet-Surgeon Donald MacIver, M.D., R.N., retired, who died at Arundel Gardens, W., on February 8th, aged 66. Educated at Edinburgh University, where he took his M.D. degree in 1861, and at St. Bartholomew's Hospital, he entered the Navy as a surgeon in 1863. Promoted to the rank of staff-surgeon in 1877, he retired in 1884 with the rank of fleet-surgeon. In 1867-68, when in the Canadian insurrection, and serving in H.M.S. *Wizard*, Dr. MacIver was ever at the call of the wounded and suffering, either Turk, Egyptian, or Cretan. These services contributed largely in maintaining peaceful relations with both belligerents. Dr. MacIver also rendered valuable services in China and elsewhere.

NATHANIEL DAVIDSON, L.R.C.S. EDIN., L.S.A.

MR. NATHANIEL DAVIDSON was born in 1805 and would have completed his century in March. Educated

at Edinburgh, he took the licence of the Edinburgh College of Surgeons in 1828, and obtained the licence of the Apothecaries' Society of London in 1829, practising for many years in George Street, Portman Square. In 1861 he obtained the licence of the Royal College of Physicians, which at that time conferred the brevet rank of "doctor," and retired about twenty-five years ago.

JAMES ALEX. INNES, M.D., C.M.ABERD.

DR. INNES, for forty years medical practitioner in Dufftown, has just died after a short illness. Deceased was born at Keithmore, Auchindoun, in 1839, and received his early education under the late Mr. John Macpherson, parochial teacher, who also taught Lord Mount Stephen, the late General Sir Donald Stewart, and other eminent men. He had a distinguished college career, graduating in medicine in 1864. He had a large local practice, and still larger consulting practice. In 1882, in appreciation of his services, a sum of £340 was collected, as a testimonial, but on his being acquainted with the fact he asked that the money be returned to the subscribers, his plea being that many gave who could ill spare it. Deceased was in his sixty-seventh year, and practised up to a few weeks previous to his death.

CAPTAIN EDWARD JOHN DOBBIN, R.A.M.C., M.R.C.S.ENG., L.R.C.P.

THIS officer, who joined the department last July, died suddenly at Tunbridge Wells at the early age of thirty-three. By his death a career of brilliant promise has been brought to a premature close. He was educated at Middlesex Hospital, and took the conjoint English diploma in 1895. In 1893 he was appointed Prosecutor of the English R.C.S., and won the Lyell Gold Medal at Middlesex Hospital in 1894, besides gaining many other distinctions.

ALFRED VAVASOUR GRIFFITHS, M.R.C.S., L.S.A.

THE place of Mr. Alfred Vavasour Griffiths as a doctor and friend will not be easily filled. He died at the age of fifty-six, from pneumonia following influenza. After receiving his medical education at Queen's College, Birmingham, Mr. Griffiths took the diploma of M.R.C.S. in 1872 and that of L.S.A. in 1873. He for many years filled a large and important place in the town life of Fenton. In his public capacity he was medical officer of health for Fenton and held many other appointments.

MAURICE LING, M.R.C.S.ENG., M.D.DUR.

IT is with much regret we note the death on February 1st of Mr. M. Ling from appendicitis at the early age of forty-five. Dr. Ling, who was educated at the London Hospital, qualified as L.S.A. in 1877, M.R.C.S.Eng. in 1878, and took the degree of M.D. Durham in 1900. He was in practice for some years at his home in Suffolk, and came to London in 1894, where he practised first in West Halkin Street and subsequently in Harley Street. A man of wide experience, even in the short time that he followed his profession in London, he obtained support from several eminent physicians and surgeons. He was known to have a practical and thorough knowledge of his profession, and was genial and courteous to all with whom he came in contact. An accomplished and exceptionally well-read and resourceful practitioner, his death will be deeply regretted by all.

GEOFFREY HETT, M.D.FDIN.

DR. GEOFFREY HETT, who died recently in his sixty-first year, was trained at King's College Hospital, where he was a prizeman in anatomy. He afterwards studied at Edinburgh University, where he graduated M.D. in 1871. Previously to settling in practice, Dr. Hett travelled, and acted as house-surgeon to the Lincoln County Hospital, and after at Weston-super-Mare. Thirty years ago he was elected to the staff of the Westbourne Provident Dispensary, giving to that

institution unstinted service. Dr. Hett enjoyed long walks, and celebrated his fiftieth birthday by walking to Brighton from London. He was for many years a member of the Harveian Society and London Lincolnshire Society. He leaves a widow, one daughter, and three sons.

RUSSIA has sustained the loss of two eminent surgeons in the persons of Dr. Alexander Broboff, professor of surgery in the University of Moscow, who was the author of various surgical works, and Professor Nicolas Sklifosovski, surgeon to the Military Medical Academy in St. Petersburg, President of the Organising Committee of the International Congress of Medicine at Moscow.

Literature.

AFTER-TREATMENT OF OPERATIONS (a)

WE must congratulate Mr. Lockhart Mummery on the success of his book. The fact that the first edition was sold out in less than a year of its publication shows that it has filled the vacancy in surgical literature for which it was designed.

In the introductory chapter a section has been added on smoking and drug habits in their relation to operative procedures, and the description of post-operative insanity has been enlarged.

When reviewing the first edition we drew attention to the excellence of the chapters on abdominal surgery; these have now been enlarged, especially the part dealing with the operation for appendicitis, their value is therefore increased. We also praised the chapter on shock and collapse, this has now been revised and, based as it is on the splendid work of Crile, forms one of the best accounts of these interesting and important conditions we have seen in any surgical work.

We have much pleasure in again strongly recommending this book not only to the practitioners and house surgeons for whom it is intended, but to every one concerned in the successful after-treatment of operations.

INTERNATIONAL CLINICS. (b)

THE third volume of the fourteenth series of "International Clinics" is, like its predecessors, very nicely got up, both as regards paper, binding, and plates. The latter being fairly numerous, and is perhaps somewhat superior to the earlier volumes of the series in the general matter that it contains. A large number, however, of the papers that it includes, although no doubt excellent as clinical instruction for a class of students, are hardly what one would seek or expect to find in a volume of this kind.

The first 120 pages are devoted to the subject of syphilis, and to this part Fournier has contributed two very interesting papers. The first of these is entitled "Syphilis and Suicide," and is bound to attract the attention of every practitioner who has had an opportunity of observing the mental effects produced by an abrupt statement to a patient that he is suffering from syphilis. The second is a valuable addition to the discussion of the value of calomel injections. Dr. Fournier is in accord with most English physicians in holding that the hypodermic treatment is by no means essential or even advisable in ordinary cases of syphilis, but he points out that, in some of the more severe types of the disease when it is necessary to strike an immediate and heavy blow at the poison, no other method will give such quick and satisfactory results. Another interesting paper in this section is that on Acute Sypnilitic Nephritis by Chauffard and Gouraud.

(a) "The After-Treatment of Operations." By P. Lockhart Mummery, F.R.C.S., Eng., B.A., M.B., B.C.Cantab, Second Edition, pp. viii, 240, with 37 illustrations, crown 8vo. Price 5s. net. London: Baillière, Tindall and Cox. 1904.

(b) "International Clinics." A Quarterly of Illustrated Clinical Lectures. Edited by A. O. J. Kelly, M.D., Philadelphia. Vol. III. Fourteenth Series, 1904. London: J. B. Lippincott Co.

The remainder of the book is filled up with a miscellany of papers on therapeutics, medicine, surgery, and gynaecology. The only one that requires special mention is that on "Foreign Bodies in the Bronchi," by Lumoyez and Guisez. In it a most successful case of removal of a nail from a bronchial tube by Killian's method is described, and a short discussion of the method itself is appended.

INVALID FEEDING. (a)

IN spite of the anonymity of the authors the 250 pages comprised in this work contain much useful information. The literary style is rather slipshod but the instructions are clear and the nurse, as well as the housekeeper, will be enabled to enlarge the sphere of their operations, to the comfort and benefit of invalids in their charge. The first half of the book is devoted to the elementary treatment of "certain prevalent diseases and maladies" (why "and maladies"?) such as fevers, gout, consumption, diabetes, &c., the second part being given up to carefully selected recipes for the preparation of food for invalids.

The general principles laid down in the first part of the work are sound and many popular fallacies are held up to ridicule. Although a number of proprietary articles of food are referred to in the text their claims are never unduly thrust upon the reader, and some of them at any rate deserve attention at the hands of practitioners. In view of the importance of the question of nourishment in morbid states this volume may advantageously be studied by all who are concerned in ministering to the requirements of invalids. It will add to their resources and enable them to attenuate the monotony of the sick diet.

RICHARDS' PRACTICAL CHEMISTRY. (b)

THE object of this book is primarily to provide medical and dental students with an introduction to elementary qualitative and quantitative chemical analysis, but it will also prove acceptable to general students. It may be suggested that the enormous number of such books is already more than sufficient to meet the demand, great as that may be; but, as the author points out in the preface, "The recent revision of the practical chemistry of the Conjoint Board Preliminary Scientific Examination has rendered considerable modification in the course of study necessary, and the book contains all the subject-matter in the new syllabus, besides additional detection tables and volumetric analysis, arranged to meet the requirements of the Preliminary Scientific Examination of the London University." The author, from his position as a lecturer to medical students, should be well acquainted with the requirements of the examinations he caters for in this book, the usual tests are given with the usual information to give the student an idea of what he is doing. Probably the author has very good reasons for placing cadmium, chromium, manganese, cobalt, nickel, strontium and lithium in a special chapter labelled "Special Tests for Metals not included in the foregoing Table," but this is the only matter in which the reviewer is not in accordance with the author. A happy idea is the devotion of four pages to a list of a few salts offering special difficulties. Another three pages will appeal to candidates the night before the examination—namely, those devoted to some 110 equations bearing on the analytical work, though this is, of course, not the use for which they were intended to be put. Directions are given for the preparation of 27 salts, volumetric analysis is treated of in a simple way, and last, but by no means least,

Part IV. is devoted to Elementary Practical Toxicology; but it might be well to jog the student's memory, that, before applying the flame to Marsh's apparatus, the hydrogen should be tested, to ascertain that all air is out of the flask.

ORGANIC CHEMISTRY FOR BEGINNERS. (a)

THIS little book is an appendix to the author's "Text-Book of Organic Chemistry," which is now well-known as a students' manual in England. To students in any branch of chemistry practical work is essential in that branch, and books treating of practical organic chemistry being by no means numerous, it is scarcely necessary to indicate what a great aid it is, to both teacher and taught, when the book on practical work comes from the pen of the author of the text-book in use at their particular establishment. The English student using this manual has this advantage over students using the Dutch copy, in that not only has the whole text been revised, but some new experiments have been added by the author, and the result is a compact and useful little manual. In most laboratories there is a considerable waste of chemicals, and in a large establishment this waste is a serious item, therefore, those who have to account for the laboratory expenditure will appreciate the following extract from the author's preface: "In most instances I have indicated the weights or volumes suitable for the reactions, an experience of many years having taught me that students always employ much larger quantities than are necessary. The amounts prescribed are approximate, and, to ensure the success of experiments, need not be weighed or measured with great accuracy." The directions for performing the various experiments are given in a clear, lucid manner, and the experiments comprise all those that an elementary student is likely to require. All the necessary references are given to enable the student to at once refer to the larger text-book for the properties, &c., of the various substances.

A very full index brings this small manual to a close.

JAVAL'S "BLIND MAN'S WORLD" (b)

A PATHETIC interest environs this work, inasmuch as it records the thoughts, experiences, and feelings of one upon whom the calamity of total blindness fell at the comparatively early age of sixty-two years. The author is the well-known ophthalmic surgeon, Dr. Javal, and the object of his work is to supply a means for showing how blind persons like himself can make themselves in some degree independent of the "sighted," and thus to render their lot in life less irksome and more contented. In the pages of "The Blind Man's World" many details will be found by which this object may be attained. Deprived of his sight suddenly the author at once set himself to work to think out little "dodges" by which he could help himself. Here is one. "In my room I have two clocks, They do not keep exactly together, and so should the first strike when I am thinking of something else, though I may fail to count it, my attention is aroused, and I listen carefully for the second one to strike. Lastly, here is a trick for finding the time at night with only an ordinary watch. Wind your watch slowly precisely at the same hour as on the previous night, and count the clicks. Suppose, there are 144 clicks, then each corresponds to ten minutes. (24 hours = 1,440 minutes). If you wound your watch before getting into bed and want to know the time during the night, wind it again slowly. You will have been in bed ten minutes for every click you hear." Apparently the author has succeeded very well in lessening the

(a) "The Art of Feeding the Invalid." By a Medical Practitioner and a Lady Professor of Cookery. London: The Scientific Press, Limited. Price 1s. 6d.

(b) "Practical Chemistry, including Simple Volumetric Analysis and Toxicology." By P. A. Ellis Richards, F.C.C., Professor of Chemistry at Queen's College, London, Public Analyst to the City of Westminster; Analyst to Charing Cross Hospital; and Assistant Lecturer on Chemistry and Toxicology in the Medical School. Pp. viii.—186. Crown 8vo. 3s. net. London: Baillière, Tindall and Cox, 1904.

(a) "A Laboratory Manual of Organic Chemistry for Beginners." By Dr. A. F. Holleman, Professor Ordinarius in the University of Groningen, Netherlands. Translated from the Dutch by A. Jamieson Walker, Ph.D. (Heidelberg), B.A., Head of the Department of Chemistry, Technical College, Derby. 18mo., riv., and 78 pages. New York: John Wiley and Sons; London: Chapman and Hall, 1904. Cloth, 1 dol. net.

(b) "The Blind Man's World: An English Version of 'Entre Aveugles.'" By Dr. Emile Javal. Translated by W. Ernest Thomson, M.A., I.M.D. London: George Putnam's Sons, Ltd., 1904.

burden of his heavy misfortune. He delights in country and town walks, enjoys riding on a tandem tricycle, concerning which method of exercise he naively remarks "the adoption of an unvarying itinerary may be poor fun for the guide, but, I, at any rate, enjoy being able to determine exactly where I am at any minute"—amuses himself with writing by means of a special writing board for blind people, which he has introduced, plays games, and always keeps his mind busy in designing new schemes for improving his helpless condition. That the work is one which everyone should read, both for pleasure and profit, is the least that can be said of this book, which has been actually written by a blind man. The work of the translator has been faithfully performed.

Literary Notes and Gossip.

FIFTY years ago a "Woman's Year Book" (A. and C. Black) would have contained notes for crochet, jam making, bead flowers, etiquette, and cosmetics; to-day it shows an open door to every profession and business, but severely states conditions of entering, to deter any who "think" they could succeed. It is a most invaluable reference work for those who are frequently asked for information on every possible employment by other women.

DR. JOHN O'CONNOR's little book of directions, entitled "Aseptic Duties of a Surgical Nurse or Dresser," published in Buenos Aires, is a complete code of surgical morality in the matter of asepsis and antiseptics. It is interleaved so that further suggestions or directions can be added. No surgical nurse or dresser should be without it.

THE copyright of that most useful and popular handbook, "Half-hours with the Microscope," by Dr. Edwin Lankester, formerly published by Messrs. W. H. Allen and Co., has been acquired by Messrs. C. Arthur Pearson, Ltd., who have also purchased the companion volume by Thomas Davies, on "The Preparation and Mounting of Microscopic Objects." The latter has been out of print for some time, but a new and cheaper edition will be published very shortly.

We have received a copy of an account book called "The Simple Medical Year Book." It is intended to be used as a private ledger by practitioners. Each page affords space for a complete record of the week's income and expenditure. The various columns include fees earned, cash received, surgery expenses, salaries, and other outlays likely to be incurred in the management of a general practice. Tables are also given into which may be entered the total income and expenditure for the four quarters, as well as for the whole year. The book is prefaced by some useful hints on the preparation of income tax returns, a matter of very great importance to medical men. A series of indexed pages for memoranda is appended. The book is certainly one which is sure to find a large number of patrons, as it is not only most useful, but it is of small size and therefore easily handled. The price is 10s. 6d. net, and the publishers are Messrs. John Bale, Sons, and Danielsson, Limited.

THE Editor of that sterling monthly, the *Boy's Own Paper*, writes us that he is constantly receiving letters from schoolmasters, teachers, boys' brigade leaders, and other workers amongst the young, asking whether it would not be possible for him to produce also a cheap magazine for lads which could be used as a reading book in schools, as well as circulated widely as an effective antidote to the trashy and even morally pernicious stuff that is constantly pouring from the Press in order to catch the teeming scholars of elementary schools. After mature consideration, he informs us that he has determined to make the attempt to produce at a cost of one penny per month, a magazine that shall not only be of current interest, but also

be worth preserving and binding, for school libraries, boys' bookshelves, and the homes of the people. In his laudable attempt to stem the degenerate tide he will have the hearty approval of all right-thinking men.

Medical News.

Small-pox Outbreak at Bombay.

AN epidemic of small-pox is reported to be causing serious anxiety at Bombay. There have been a hundred deaths from the disease within a week in the city of Bombay, and there are hundreds of cases in the hospitals. The anxiety over the outbreak is aggravated by the reluctance of natives to be vaccinated and to submit to segregation.

A New Hospital Auxillary.

SIR FREDERICK TREVES, speaking last Thursday at a dinner given in aid of a Home of Recovery, to be built in Surrey (patroness, Princess Louise), said the present pressure on London hospitals was not brought about, as many imagined, by those coming who could afford help elsewhere. The population has increased enormously, yet neither in that did the reason lie, but in the fact of the astounding change which had taken place in surgery. He had been twenty-five years at one hospital, and on first entering there was one operating theatre occupied one afternoon a week for two hours. That same hospital had to-day six theatres open every day and nearly all day. Operations were now possible which fifty, even twenty years ago, would have been deemed hopeless and the suggestors madmen. The work had increased three hundred-fold. But the pathetic side was that even after skilful operation, patients had often, through pressure of space, to go away with wounds partly healed, and these cases no convalescent home would take. They drifted back to homes where stamp-paper, a hairpin and the family sponge were the only surgical tools. The scheme of a Home of Recovery was one of the wisest ever made, and would have the support of every London hospital. Over £1,300 was subscribed during the evening.

Royal College of Physicians of London and the Royal College of Surgeons of England—Diploma in Public Health.

THE following are the names of the seventeen candidates who are recommended by the Examiners for the diploma, viz:—Arthur Reginald Bankart (M.V.O.), M.B., C.M.Edin., John Cullen, M.D., Ch.B.Glas., Alfred George Edsell, M.D.Dur., L.R.C.P., M.R.C.S., L.S.A., William Lloyd Edwards, L.R.C.P., M.R.C.S., Edward Haines, L.R.C.P., M.R.C.S., Oswald Horrocks, L.M. and S.Madras; L.R.C.P. and S., F.R.C.S.E., Oliver Richard Archer Julian (C.M.G.), (Major, R.A.M.C.), L.R.C.P., M.R.C.S., L.S.A., Charles Randolph Kilkelly (C.M.G.) (Surg.-Maj. Grenadier Guards), M.B., B.Ch.Dublin; L.R.C.S.I., Frederick Norton Menzies, M.D., B.S., and M.R.C.P.Edin., Robert Macfarlane Mitchell, M.B., Ch.B.Edin., F.R.C.S.Ed., Arthur Hugh Morris (Capt. R.A.M.C.), L.R.C.P., M.R.C.S., Albert Pearse (Major R.A.M.C.), L.R.C.P., M.R.C.S., John Richards, L.R.C.P., M.R.C.S., Frank Edward Scrase, F.R.C.S., L.R.C.P., Harold Weightman Sinclair, M.D.Lond., L.R.C.P., M.R.C.S., Robert Small, L.R.C.P., M.R.C.S., Frederick Robert Elliston Wright, M.B.Lond., L.R.C.P., M.R.C.S.

IN our last issue we referred to the prize competition organised by Messrs. Wright, Layman and Umney, and remarked that it would be interesting to learn how the standard test number is arrived at. We now learn that the figures were arrived at in the following manner: All the numbers given by the competitors were added together and divided by the total number of competitors the number ascertained being 1702, and a cheque for £50 was sent to Miss Edith Burn, Didsbury, near Manchester, who alone sent in the correct figures. We understand that many thousands of people went in for this competition throughout Great Britain and Ireland, and therefore it represents the exact average, which is approximately one which might have been expected.

Notices to Correspondents, Short Letters, &c.

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

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 re-forwarding 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.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the publisher of printer before the type has been distributed. This should be done when returning proofs.

TEST.—In chronic urethritis a capable use of the urethroscope will in most cases locate the infected area.

COUNTRY SURGEON.—Correct glasses avail little or nothing if the frame be ill-fitting. Take the pupillary distance, height of bridge, angle of crest of bridge, width of bridge on pupillary line, width of bridge at base, depth of bridge, temple length, temple distance. Submit this to a respectable optician who is not certified by the Spectacle Makers Company.

DISPENSER (Surbiton).—It is not an uncommon experience that drugs given for an entirely different purpose have relieved symptoms it was not proposed to treat. Needless to say that fact does not warrant haphazard prescribing.

DR. P. S.—Rosenbach's *Physician v. Bacteriologist* has been translated into English by Dr. A. Rose, New York. Rosenbach is the author of over twenty books, and contributed to Nothnagel's Encyclopaedia. It is a good book of reference.

F. K. BOBSON (Lancs.).—The best plan of meeting the difficulty is to induce the local sanitary authority to institute a system of free bacteriological tests. Where diphtheria has so firm a hold over an insanitary district such as you describe the only hope of making headway lies in the early detection of cases, and that again depends in many instances entirely on early bacteriological diagnosis.

DR. M. C.—Our inquiries have elicited nothing definite, but we understand there is a probability that the matter will be brought up at the next meeting of the Council.

L.R.C.P., M.R.C.S.—The most practical, and at the same time, the most successful "Manual of Medicine," which has come under our notice is that by Dr. Monro of Glasgow. It occupies a position midway between the larger "systems" and the smaller so-called cram books, and is excellently suited to the requirements of men in general practice.

MR. A. WILSON HOGG is thanked for report of case, which is marked for early insertion.

ESQUIRER.—The person referred to is a quack of the worst type. Have nothing to do with him, his guarantees are a sham and a snare for your money. You may if you please give him this as our testimonial.

HY. S. WILSON.—We do not prescribe in these columns, and you may take it as a rule, with few exceptions, that where this is done in lay journals, the prescription by post is valueless as without personal examination and interrogation, a correct view of disease cannot be formed.

DR. HYSLOP is thanked for his communication.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, FEBRUARY 22nd.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus, E.C.).—8.30 p.m. Paper:—Mr. A. H. Tubby.

MEDICAL GRADUATES' COLLEGE and POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. A. H. Tubby: Clinique. (Surgical.) 5.15 p.m. Dr. F. Horrocks: A Case of Concealed Menstruation with Remarks on Treatment.

CENTRAL LONDON THROAT and EAR HOSPITAL (Gray's Inn Road, W.C.).—5 p.m. Demonstration:—Dr. W. Wingrave: Ear.

THURSDAY, FEBRUARY 23rd.

MEDICAL GRADUATES' COLLEGE and POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Mr. E. Clarke: Ocular Headache: Its Causes, Diagnosis, and Treatment.

MOUNT VERNON HOSPITAL for CONSUMPTION and DISEASES of the CHEST (7 Fitzroy Square, W.).—5 p.m. Lecture: Dr. T. N. Kelynaok: The Diagnosis and Treatment of Pulmonary Cavities (Post-Graduate Course.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Dr. G. N. Meachen: Demonstration of Skin Cases.

FRIDAY, FEBRUARY 24th.

CLINICAL SOCIETY of LONDON (20 Hanover Square, W.).—8 p.m. Exhibition of Clinical Cases followed by Discussion. Patients will be in attendance from 8 to 9 p.m.
MEDICAL GRADUATES' COLLEGE and POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Dr. L. Lack: Clinique. (Throat.)

MONDAY, FEBRUARY 27th.

ODONTOLOGICAL SOCIETY of GREAT BRITAIN (20 Hanover Square, W.).—The Chair will be taken at 8 p.m. Casual Communications will be given by Mr. Stanley P. Mummery, L.R.C.P., M.R.C.S., L.D.S.Eng., on "A reliable Method of Bleaching Teeth," and by Mr. Frank Morley, L.R.C.P., M.R.C.S., L.D.S.Eng., on "A Case of Gangrene of the Lung following Tooth Extraction." A paper will be read by Mr. A. Hopewell-Smith, L.R.C.P., M.B.C.S., L.D.S.Eng., on "Some rare Anomalies of the Teeth." The Paper will be illustrated with Lantern Slides and Microscopic Preparations.

TUESDAY, FEBRUARY 28th.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—8.30 p.m. Dr. H. Corner: Demonstration on General Paralysis at Colney Hatch Asylum, New Southgate, N.

Vacancies.

Abergwynn Workmen's Medical Fund—Fully qualified Practitioner, to take charge of the practice. Salary £400 per annum. Applications to Thos. Bevan, 40, High Street, Abergwynn, South Wales.

Denbighshire Infirmary, Denbigh.—House Surgeon. Salary £100 per annum, with board, residence, and washing. Applications to J. Parry Jones, Secretary.

Open-air Treatment.—High-class Sanatorium.—House Physician. Salary £130 per annum, with board and residence. Applications to Physico, care of Gould's Advertising Agency, 54 New Oxford Street, W.C.

East London Hospital for Children and Dispensary for Women, Shadwell, E.—Medical Officer for the Casualty Department. Salary £100 per annum. Applications to Thomas Hayes, Secretary.

North Cambridgeshire Hospital, Wisbech.—Resident Medical Officer. Salary £100 per annum, with furnished rooms, attendance, coal, gas, and washing, but not including board. Applications to William F. Bray, Secretary, Wisbech.

Kensington Board of Guardians.—First Assistant Resident Medical Officer. Salary £120 per annum, with apartments, board, and washing. Applications to the Clerk to the Guardians, 3, Carlos Road, Kensington.

Royal Buckinghamshire Hospital, Aylesbury.—House Surgeon. Salary £100 per annum, with board, and furnished apartments. Applications to Geo. Fell, Secretary, Rickford's Hill, Aylesbury.

Birkenhead and Wirral Children's Hospital, Woodchurch Road, Birkenhead.—Male House Surgeon. Salary £100 per annum, with board, residence, and laundry. Applications to F. W. Archer, 25 Storeton Road, Birkenhead.

Lincoln County Hospital.—Senior Male House Surgeon. Salary £100 per annum, with board, lodging, and washing. Applications to the Secretary, 2 Bank Street, Lincoln.

Appointments.

BROWN, A., L.R.C.P.I., M.R.C.S.Eng., Certifying Surgeon under the Factory and Workshop Act for the Masham District of the county of York.

BURSHARD, F. F., M.D., M.S.Lond., F.R.C.S.Eng., Consulting Surgeon to the Bromley Cottage Hospital.

BURTON-BROWN, F. H., M.D.Oxon, Clinical Assistant to the Chelsea Hospital for Women.

DOORLY, P. F., L.R.C.P., M.R.C.S.Edin., L.F.P.S.G., Certifying Surgeon under the Factory and Workshop Act for the Carrick-on-Shannon No. 2 District of the county of Roscommon.

FORTESCUE-BRICKDALE, J. M., M.A., M.D.Oxon, Out-patient Physician and Pathologist to the Royal Hospital for Sick Children and Women, Bristol.

GEDGE, ARTHUR SYDNEY, M.R.C.S., L.R.C.P.Lond., Medical Officer for the Fifth District of the Devises Union.

HARRIS, WILFRED J., M.D.Cantab., Physician in Charge of Out-patients at St. Mary's Hospital, Paddington, W.

Births.

PRITCHARD.—On February 17th, at Wellington Square, Hastings, the wife of W. Clowes Pritchard, M.R.C.S., L.R.C.P., of a son.

Marriages.

SHERRARD-CRAIG.—On February 17th, at the Cathedral, Bombay, James William Sherrard, Indian Army, son of Colonel C. W. Sherrard, R.E., to Margaret, only daughter of James Craig, M.D., Beckenham.

Deaths.

TOMLINSON.—On February 17th, at 8 Earl's Avenue, Folkstone, Lt.-Colonel Edward Denham Tomlinson, M.D., late of the R.A.M.C. and York and Lancaster Regiment, in his 69th year.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXX.

WEDNESDAY, MARCH 1, 1905.

No. 9.

Original Communications.

DERMATO-MYOSITIS OR ACUTE POLYMYOSITIS.

By WILLIAM MURRELL, M.D., F.R.C.P.,

Physician to the Westminster Hospital; Lecturer on Clinical Medicine and Joint Lecturer on Medicine.

IN most text-books on medicine there is a short article on myositis, or inflammation of the muscles, but that particular variety known as dermatomyositis is rarely referred to or is merely mentioned. Cases of this disease are so uncommon in this country that the name is practically unknown. The following case seems worthy of record:—

A woman, æt. 23, after an illness of three weeks' duration, was admitted on December 6th, 1904, with febrile disturbance and tenderness of the voluntary muscles. The temperature ranged daily from 99.8° to 102.8°. The muscles of the arms and legs, of the thorax and abdomen, of the back and neck, were equally affected. The slightest pressure gave rise to lively manifestations of pain. The tenderness was not along the course of the nerves and none of the articulations were involved. There was some œdema of the ankles, and there had been some of the face. The urine contained no albumin. The red blood corpuscles numbered on admission 5,580,000 per c.mm., and the white 28,000, with hæmoglobin 80 per cent. Three weeks later, when the acute symptoms had subsided, the reds were 4,200,000 and the whites 19,600, with hæmoglobin 70 per cent. The attack commenced with tonsillitis and pain and swelling on the left side of the face, and there was gastro-intestinal disturbance for a day or two. There was profuse sweating, but no eruption. There was a history of pains in the thighs, both back and front, in the calves, in the dorsum of the feet for a fortnight, and of pains in the flexor aspect of the arms and forearms for a week. A difficulty had been experienced in walking and in moving the arms and fingers. The deep reflexes, with the exception of that of the right triceps, could not be elicited. There was no wasting and no fibrillation. The patient had always resided in London, and there was no history of any previous illness with the exception of gastric ulcer with hæmatemesis at the age of 17. The patient had not menstruated for three months, but there was no disease of the pelvic organs.

Trichiniasis was suspected, and under an

anæsthetic a considerable fragment of the gastrocnemius and soleus was excised, but no trichina spiralis could be detected. Sections of the muscles were cut, and were normal in appearance. The motions were carefully examined, but nothing was found. Widal's reaction was not given. The fever gradually subsided at the expiration of ten days from admission, but the tenderness persisted for a fortnight longer, becoming little by little less acute. The patient was kept under observation for another month, but there was no further development.

This case presents many points of interest. It was clearly not an ordinary case of muscular rheumatism. In that complaint there is usually a more or less definite history of exposure to wet or cold. As a rule, although not invariably, one group of muscles, or groups of muscles functionally related, is attacked. This is so generally recognised that the nomenclature is typographical. There is little or no constitutional disturbance, and there is little if any elevation of temperature. This last fact is well illustrated by a very severe case of muscular rheumatism recently under my care. The patient was a carpenter, æt. 34, living at Eastbourne. Towards the end of January he was attacked suddenly with pain and stiffness in the muscles of the left thigh, in the right biceps and lumbar region. He stated that for some days previously he had been working in an open shop exposed to a cold east wind. He sought relief not because he felt ill, but from his inability to follow his occupation. His temperature was taken systematically for ten days, and only twice rose to 100° F.

The probabilities are that the case here recorded was a toxic myositis, the point of entrance of the poison being the tonsils. It bears a striking resemblance to the disease known as dermatomyositis, although some of the characteristic symptoms were absent. Dermo-myositis is rare in this country, but several cases have been recorded in Germany, and it is said to be common in Japan. It was not known as a clinical entity until 1887, when P. Hepp, (1) E. Wagner, (2) and Unverricht (3) each independently described an unknown disease so closely resembling trichiniasis in its features that it was called by the first-named "pseudo-trichiniasis," a form of nomenclature utterly indefensible. In 1891 Unverricht (4) published his second case, and suggested the term dermatomyositis. Prior to Unverricht's first publication, Wagner (5) in 1863 had described "A Case of Rare Muscular Disease," and in 1875 Potain (6) had recorded a somewhat

similar case, but regarded it as a chronic morvian disease, a kind of bastard glanders, with anomalous symptoms. In 1897 Kürt von Bultzingslöwen, of Breslau, (7) published a thesis of thirty pages, and a temperature chart on dermato-myositis. The first case in France, with the exception of Potain's, occurred in the clinique of Professor R. Lépine, of the Hôtel-Dieu at Lyons, and was reported by Dr. L. M. Bonnet (8). In 1903 Dr. F. Frochheimer, of Cincinnati, (9) published a detailed account of a typical case in a woman, æt. 40. Last year Dr. John Hill Abram, (10) of the Liverpool Royal Infirmary, published two cases of infective myositis, one of which was clearly septic in origin, and proved fatal.

The symptoms of dermo-myositis are fairly constant and characteristic. The onset is gradual, and little or nothing is known as to its causation. The fever is continuous, except in the septic cases, and never attains a high degree of intensity. There is always pain and tenderness of the muscles, with usually a considerable amount of œdema. The muscles may be attacked simultaneously or successively. When the muscles of the pharynx and larynx are involved death usually ensues from aspiration pneumonia. The spleen in most cases is enlarged. There is usually profuse sweating, and there may be eruptions of various kinds, especially erythema, urticaria, and herpes. It is not essential to the diagnosis that all these symptoms should be present, and in one of Unverricht's cases there was no fever, no sweating, no enlargement of the spleen, and no rash. In the present case, the patient was ill for three weeks before she came under observation, and it is possible that during that time there may have been a rash of which we have no record. The high percentage of red and white blood corpuscles, especially the latter, is notable. In Frochheimer's case the erythrocytes numbered only 4,102,000, and the white cells 5,200 per c.mm. The duration of the disease is variable. It may run an acute course in from one to eight weeks, or it may become chronic, lasting a year or more. In one case convalescence was greatly prolonged, and the patient had not fully recovered at the expiration of two years. The prognosis is by no means good, and in 15 cases there were 11 deaths, of which 6 were from secondary pneumonia.

There are many other forms of polymyositis. In September, 1888, Dr. George W. Jacoby, of New York, (11) read before the American Neurological Association a paper on "Subacute Progressive Polymyositis," in which he gave a comprehensive review of our knowledge of the subject. Lorenz, in 1898, in an article in "Nothnagel's Encyclopædia," collected seventeen cases of muscle inflammation, and classified them. The myositis due to traumatism or operative measures falls within the province of the surgeon. Enteric myositis, a waxy or granular degeneration of the striated fibres, is not uncommon, but the symptoms are slight and the pain and tenderness on pressure are never pronounced. It has been seen in cases of scleroderma, and gonorrhœal myositis, affecting chiefly the muscles of the neck, is not unknown. Suppurative myositis is usually due to streptococcus infection, and is best treated with serum. In some cases there are various forms of hæmorrhage, and in others the disease is associated with erythema nodosum. The chronic form may be the precursor of myositis ossificans,

and two years ago I had in the hospital a man, æt. 34, in whom every muscle of the body showed ossification.

- (1) *Berliner klin. Woch.*, 1887, p. 389.
- (2) *Deutsches Archiv. f. klin. Med.*, xl, 1887, p. 241.
- (3) *Zeitschrift f. klin. Med.*, xii, 1887.
- (4) *Deutsch. med. Woch.*, 1891, 2.
- (5) *Archiv f. Heilkunde*, iv, 1863.
- (6) "Morve chronique de Forme anormale." *Bulletins de la Societe Med. des Hôpitaux de Paris*, 1875, p. 314.
- (7) Berlin: Buchdruckerei von Gustave Schade.
- (8) *Lyon Medical*, 1901, xcvi, 10.
- (9) *Boston Medical and Surgical Journal*, 1903, cxlviii, 631.
- (10) *Lancet*, November 12th, 1904, 1341.
- (11) *Journal of Nervous and Mental Diseases*, 1888, xv, 697.

THE LINCOLN EPIDEMIC AND THE LATENCY OF ENTERIC FEVER INFECTION.

By P. G. GRIFFITH, M.B., B.Ch.

Horsney.

THE outbreak of typhoid fever in Lincoln prompts me to anticipate somewhat the results of an investigation I have been engaged in for some time with regard to the etiology of this disease, since it seems possible that the conclusion I have already arrived at may be of some small value. The objects I have in view in pursuing the investigation referred to are to determine the lethal effect of the gastric and pancreatic juices on typhoid bacilli and to ascertain if these organisms are often present in the alimentary canals of healthy subjects without producing typhoid fever.

The influence of the digestive juices on the specific organism of typhoid fever seems to have been overlooked as a factor in the etiology of the disease. By one authority it is stated that gastric juice kills *B. typhosus* in ten minutes. My own experiments do not confirm this, but as far as they go it appears safe to assume that an exposure for two hours to healthy gastric juice at the body temperature is fatal to their existence. Pancreatic juice appears to have an equally fatal influence. It is therefore probable that when these organisms are introduced into the alimentary canal of a healthy individual *with* food, their chance of surviving until they reach a place of safety in the lower ileum, where pancreatic digestion ceases, is exceedingly remote. It is otherwise when the organisms obtain admission in water partaken of apart from food or in any other liquid whose presence does not act as a stimulus to the secretion of the digestive juices. Water when so imbibed in any quantity passes almost immediately from the stomach to the small intestine and finds its way to some extent to the lower bowel before it is all absorbed. A ready means is thus provided for the bacilli to escape the destructive influence of the digestive juices.

But it is more than probable that the bacilli may thus secure admission to the lower alimentary canal, and yet fail to produce typhoid fever, or to do so after a much longer interval than has been considered possible. The following considerations appear to render this a certainty. In an epidemic that occurred in Armagh in 1902 the conditions were such that the possibility of secondary infection could be excluded, yet in no less than 29 cases the disease was developed at

periods ranging from 25 to 46 days from the first time of exposure. In these cases the specific organism of the disease must have found a resting place in the intestines for weeks before it was able to effect an entrance to the tissues. In the *British Medical Journal*, 1902, vol. ii, p. 839, a suggestive case is recounted where exposure to infection ceased on January 15th, but the disease did not develop until the end of April. Chantemesse and other observers have discovered the typhoid bacillus in the stools of healthy individuals and in those of patients recovering from typhoid forty-six days after the cessation of fever. Taking these facts into consideration, with the knowledge we possess of the viability of the organism under conditions such as it would encounter in the lower alimentary tract, it is impossible, I submit, to come to any other conclusion than that it must be a common occurrence for individuals to harbour typhoid bacilli for considerable periods before they are infected with the disease or without suffering any inconvenience at all.

Under such circumstances the condition of immunity acquired by a previous attack or one artificially induced must be an important factor in the prevention of the disease, but I submit that of even greater importance is the condition of the mucous membrane of the lower alimentary tract. The frequency of relapses, or re-infections, as I would call them, in this disease is a strong proof of the feeble immunity conferred by an attack, and the well-known danger of improper feeding in the period of convalescence appears to me to be due to its evil effect on the alimentary mucous membrane lessening the resistance of the latter to a second invasion.

Dr. Howard Tooth, in an account of his experience of this disease in the South African war, suggested the probability of the bacilli finding a temporary home in the intestinal canal. He says: "It is conceivable, nay more probable, that every man in these great camps may have at times received into his alimentary canal enteric bacilli which may have grown and multiplied, but without producing the characteristic disease." And later he goes on to say: "We were struck by the fact that in many of our cases the enteric fever attack appeared in the course of dysentery. I strongly suspect that the two diseases may co-exist, and that such a conjunction may be of unfavourable omen. . . . Diarrhoea and dysentery in themselves proved as a rule very amenable to treatment, but in the light of the foregoing remarks the slightest diarrhoea becomes invested with a new importance."

The virulence of the typhoid bacillus has been shown experimentally by Sanarelli to be much increased by the presence in the blood of the toxins of other organisms such as the *Bacillus coli*, and to this Dr. Tooth attributed the danger of minor intestinal derangements. But it appears to me probable that an even more pernicious influence may be exercised by them in their destructive effect on the lining of the alimentary tract. They break down the most important defence to the typhoid invasion and increase the force of that invasion indefinitely—so that no immunity that Nature or art can bestow is sufficient to withstand the attack.

If the etiology of typhoid be looked at from the standpoint I have endeavoured to elucidate,

an explanation will be found for a very striking peculiarity of all water epidemics of any magnitude, *viz.*: the continuance of the epidemic for some time after the polluted water has been cut off. For example—in the Maidstone epidemic of 1897 the polluted water was cut off in the first week of October, yet no less than 134 cases fell between October 20th and November 20th. These were described at the time as secondary cases, and while this is doubtless true with respect to a certain small proportion of them, it is far more likely that the majority contracted the disease from the infected water.

In Lincoln there are probably many people now who are the unwilling hosts of typhoid bacilli, multiplying in number, and waiting a favourable opportunity for attack. Nor is the danger confined to the hosts alone, for they may also be the unwilling cause of infecting others, since it is more than likely that many of these people, without ever suffering themselves, may yet act as disseminators of the disease.

THE TREATMENT OF CONVALESCENCE:

WITH SPECIAL REFERENCE TO THE VALUE OF
IRON.

By JAMES BURNET, M.A., M.D., M.R.C.P. Edin.,
Senior Clinical Tutor, Extramural Wards, Royal Infirmary;
Registrar, Royal Hospital for Sick Children; and Physician
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IN considering the treatment of disease we are all somewhat apt to regard lightly, or even in some cases to neglect altogether, the period of convalescence. Still, if we reflect for a moment, we at once recognise that treatment does not really end until the period of convalescence is over, and the patient has resumed his every-day duties. There is no doubt that many serious organic changes take place during convalescence from acute disease. All serious illness weakens the various organs, more especially the heart, lungs, kidneys and central nervous system. These organs are all more or less affected by the onset, and during the progress of any acute illness. Hence we are not surprised to find that during convalescence a patient may become affected by some secondary disease which may in some instances tend greatly to shorten his life.

Convalescence may be rapid or it may be retarded. This will, to a certain extent, depend on the recuperative power of the patient, but also largely on the management and treatment of the convalescent period. Slow and greatly retarded convalescence is seen after influenza, enteric fever, and acute rheumatism, as well as after certain surgical affections. It is also apt to be prolonged in some of the diseases of childhood, such as pneumonia, and especially rheumatic heart conditions. Again we observe that after serious labours, especially those involving much loss of blood, the period of convalescence is very slow and uncertain.

Now what does this retarded convalescence mean to the individual? It prevents his returning to work—an important matter in the majority of cases. Again, nervous and intellectual vigour are apt to become impaired, while at the same time the general bodily strength becomes more and more enfeebled. In the case of female patients there is always the danger lest a condition of chronic invalidism and of neurasthenia become developed; while children run the risk of retarded growth, both of body and of brain. Apart, however, from these considerations we have to remember that when the tissues have become weakened by disease the entrance into them of other pathogenic organisms becomes an easier matter, and it is during the period of convalescence that this inroad is most likely to take place. For example, most of us have seen cases in which a patient recovering

with difficulty from some severe illness has developed tuberculosis, especially where there was a previous predisposition to the disease. In other cases we find that pernicious anæmia, and even malignant changes, have had their origin during the convalescent period, especially where the latter was slow and unsatisfactory.

In view of what we have stated, it will be at once apparent that it is a grave mistake to deal carelessly with patients during their convalescence. Their treatment at this stage is often of the utmost importance, while in not a few cases their future well-being may largely depend on the care with which we bring them back through convalescence to a state of more or less perfect health and strength.

We may look at the treatment of convalescence under three headings—(1) Dietetic, (2) Hygienic, and (3) Medicinal.

Regarding the dieting of patients during convalescence little need be said, save to remind ourselves of the fact that the question of diet is very much neglected, and yet we must in every case strive to appeal to our patient's appetite by presenting to him such food materials as are both pleasing to the palate and at the same time of sufficient nutritive value. As a general rule convalescent patients require much food, and the more they can be coaxed to take the better. It may be well to point out that medicated wines are seldom commendable, and in the case of female patients to be avoided altogether lest intemperate habits be formed. In ordinary cases, however, burgundy, port wine, and it may be whisky, are sometimes prescribed with advantage.

The hygienic measures to be adopted during convalescence are those which govern our everyday practice. Abundance of fresh air and sunlight are necessary in every case, and we must see to it that the patient obtains these as far as possible. Change of air and scene will usually produce beneficial effects, especially after depressing illness, such as influenza.

The medicinal treatment of convalescence must be referred to at somewhat greater length, as it is the mode of treatment which often proves so unsatisfactory. Tonics are indicated in practically every case; but all cases are not alike, and consequently the form of tonic which is prescribed with most satisfactory results to one patient may fail altogether in its therapeutic effect when given to another. It is not by any means an easy matter to explain why this should be, but that such is the case must be the experience of every physician. Probably the solution to the difficulty is obtained by inquiring carefully as to the ultimate cause of the retarded convalescence in every individual case. When we do this it will not infrequently be found that a condition of anæmia has been induced, and until this has been got rid of we cannot possibly expect the patient to be well and able for his duties.

Anæmia is certainly largely accountable for the retarded convalescence following on acute rheumatism, nephritis, enteric fever, childbirth and surgical operations generally. This being so, how are we to deal with this secondary anæmia? The erythrocytes may be as low as 2,500,000 per c.mm., and the hæmoglobin 40 per cent. or even less. In such cases little or no benefit will result by giving either hypophosphites or glycerophosphates, though these are largely prescribed at the present time. Neither can we expect any good results from arsenical preparations, or from those containing manganese. It is iron that we look to in such cases as our sheet anchor, but much will depend on our choice of the preparation to be given. The perchloride is too astringent, upsets the stomach and produces constipation, with a coated tongue as well as loss of appetite. The same objections may be raised against the sulphate. The saccharated carbonate is more satisfactory, but its action is too slow for our present purpose. What we need is a remedy which will produce immediate and rapidly progressive benefit to the convalescing patient. Recently a preparation, known as iron vitellin, has been exten-

sively used here and abroad, and in it we believe a distinct advance has been realised in iron therapy.

Iron vitellin, or, as it is otherwise termed, ovoferrin, is an organic compound produced by Drs. A. C. Barnes and Hermann Hille, of Philadelphia. It is a clear, red fluid, with neutral reaction, and both odourless and tasteless. Its chemical formula is $C_6 N_7 S, H_3 Fe_3 O_{22}$. It is synthesised from serum albumen and iron tartarate, and is undoubtedly a true metallo-organic derivative. The minimum dose is two drachms thrice daily, in a wineglassful of water. Apart altogether from its use in convalescence, it may be given to children, and at present we are engaged in a series of observations in connection with this valuable use of it. Recently it has proved of service in the treatment of pernicious anæmia.

The following brief notes of actual cases in which iron vitellin was employed show that it acts better in convalescence than do the usually employed tonics and reconstructives.

CASE I.—A. Y., a girl, æt. 7, who had been operated on for enlarged tonsils and adenoids. She remained feeble and had no appetite. Various remedies were tried, including cod-liver oil and two preparations of iron. Finally, recourse was had to iron vitellin, at first in teaspoonful doses, later in tablespoonful, and finally in one ounce doses. Under this treatment the child rapidly regained strength, the colour returned to her face, and a month later she was in the enjoyment of perfect health.

CASE II.—J. M., male, æt. 24, had a severe attack of enteric fever with high temperature. He had a plentiful eruption of typical spots, and for a fortnight there was fairly profuse diarrhœa. It was not until the beginning of the fifth week that the temperature fell to normal. Ten days later he was placed on light solid food, but his progress towards convalescence was slow. For a fortnight he was so weak that it was only with difficulty that he could walk a few steps into an adjoining room. Change of air was tried, and he was sent to the seaside, where he remained for three weeks. While there he improved somewhat, but his powers of locomotion were very limited, and there was complete incapacity for mental exertion. He was put first on hypophosphites and then on glycerophosphates, but without much improvement resulting. An examination of the blood was then made, when it was found that the red cells numbered 3,400,000 per c.mm., the leucocytes 7,000, while the hæmoglobin was reduced to nearly 40 per cent. This seemed to be a clear indication for the use of iron, and accordingly iron vitellin was given in full doses three times daily. At the expiration of a week the red cells numbered 4,240,000 and the hæmoglobin was 52 per cent., while there was a notable improvement in the patient's condition, physical as well as mental. Another week of the same treatment was marked by still further improvement, and he was now able to walk a considerable distance without difficulty or fatigue. He regained his appetite, and from being pallid and flabby rapidly put on flesh. The red corpuscles were now 4,960,000, and the hæmoglobin was 50 per cent. From this time he progressed steadily, and eventually made a complete recovery.

CASE III.—C. R., male, æt. 35. This was a bad case of influenza, complicated with pneumonia. The patient led a sedentary and studious life. He had had four previous attacks of influenza, although none of them were of so serious a type or attended by complications. He was left weak and destitute of energy. He had little or no initiative power, and found that the slightest effort at writing even a simple letter left him tired and exhausted. He was markedly anæmic, his red corpuscles being only 3,150,000 and the hæmoglobin scarcely 35 per cent. He was placed on reduced iron, but this produced nausea, and entirely upset his digestion. It was persevered with for ten days, but with practically no improvement either in his symptoms or in the condition of the blood. Iron vitellin was then tried, cautiously at first, and then in larger doses. At the expiration of a fortnight, the

red corpuscles had increased exactly one million, and the percentage of hæmoglobin had risen to 49 per cent. A fortnight later his lassitude had entirely disappeared, the red cells were 5,100,000, and the hæmoglobin was found to be 57 per cent.

Equally favourable results were obtained in two cases of fibroid disease of the lungs in which iron vitellin was administered regularly and in full doses.

CASE IV.—T. R. This was the case of a lad about 16 years of age, who had repeated attacks of profuse epistaxis which were checked with difficulty. The bleeding was entirely from the right nostril and a tender spot was found on the anterior part of the septum. The patient looked very ill and anæmic, and suffered greatly from headache and lack of strength and energy. Various local astringents had been tried, but these only gave temporary relief, and the bleeding recommenced as soon as they were discontinued. A blood count was then made, and this showed that the red cells only numbered 3,950,000, the hæmoglobin being 44 per cent. The patient was given iron vitellin three times a day for four days, when the red cells numbered 4,320,000, with hæmoglobin 48 per cent. Four days later, under the same treatment, the red cells had risen to 4,850,000 and the hæmoglobin to 53 per cent. On the expiration of another four days the red cells were found to be 5,260,000, and the hæmoglobin 60 per cent. The patient's general condition was improved to a marked extent under this treatment. His appetite was greatly increased, the bowels became more regular in action, and the patient's capacity for work was distinctly increased. There has now been no return of the epistaxis for nearly three months, but the patient still continues to take iron vitellin from time to time.

CASE V.—R. M., æt. 56. This patient was a business man, stout and flabby, who habitually dined well and took no exercise. He had long suffered from internal hæmorrhoids which caused him no little inconvenience. His liver was considerably enlarged and the urine was loaded with urates, while it contained more than a trace of albumin. An examination of the blood showed that, in spite of his plethoric appearance the patient was really anæmic. His erythrocytes numbered only 3,700,000 per c.mm., while the hæmoglobin was reduced to 40 per cent. This was the average of several observations. The question of operation was discussed but negatived. He was given a mixture containing sulphate of iron with sulphate of magnesia, but this produced headache and much distress, probably due to the condition of his arteries. He was induced to give up using purgatives, and was ordered a drachm of iron vitellin in a wineglassful of water thrice daily. After the third day the bowels acted naturally. The dose was then increased to half an ounce. At the expiration of four days the red cells had increased to 4,000,000, and the hæmoglobin by 4 per cent. A week later his red cells were 4,800,000 and there was still further improvement in the hæmoglobin percentage. He continued taking the iron vitellin for a month, and little by little the bleeding from the piles ceased. He soon regained his accustomed mental energy, and is now in the enjoyment of fairly good health.

In addition to the above cited cases we have used iron vitellin in the treatment of a number of other patients convalescing from typhoid fever, influenza, pneumonia, diphtheria, and rheumatic fever, and have been much impressed with its influence in increasing the blood constituents, and in improving the tone and general well-being. An analysis of these results concerning the effects of iron vitellin in convalescence and in secondary anæmia warrant the following conclusions:—

1. It is readily assimilated. It does not blacken the teeth, and it does not upset the stomach, nor produce constipation or headache.
2. As a tonic it acts promptly and rapidly, while its administration may be continued for long periods without producing deleterious effects.
3. It is palatable and absolutely non-astringent.

4. It acts powerfully as a hæmatinic, and also specifically by imparting tone to the system.

The Out-Patient Departments.

NATIONAL HOSPITAL FOR DISEASES OF THE HEART.

Case of an Unusually Slow Pulse.

By R. O. MOON, M.D. Oxon., M.R.C.P.,
Physician to the Hospital.

A.W., a carpenter, æt. 58, came up to my out-patient department at the Heart Hospital, in January, 1904, with the not uncommon complaint of "pains round the heart, flatulence and fainting attacks." To my surprise, on putting my fingers on his pulse, there were only twenty-six beats in the minute. It was, however, quite regular and of moderate tension. On examining the heart, it was clear that the apex beat and radial pulse fully corresponded. The impulse was in the normal position, but slightly diffuse; there was no murmur or anything unusual in the sounds of the heart.

Family History.—He comes of a healthy and long-lived stock, his father having lived to the age of ninety-nine, and his mother to ninety-six.

Previous History.—He says that he has always enjoyed excellent health until four years prior to his coming to the hospital, having seldom had to see a doctor. He had, however, twelve years ago a mild attack of influenza, in the course of which he recollects the doctor having commented on the slowness of his pulse, but it certainly caused him no symptoms at that time. Eight years later, in 1900, while on some scaffolding, he suddenly fell backwards in a faint, and would have fallen from a great height had he not been supported by a bricklayer who was standing by. For the next week he felt quite well, and then had another similar attack. After that they recurred at intervals of six months, until June, 1903, when they began to come on with great frequency—several times a week. In an attack he would fall to the ground with the suddenness of an epileptic seizure, remain unconscious for half a minute, and then, on regaining his senses, feel perfectly well. On two occasions he injured his head slightly in these attacks; he had, however, never bitten his tongue nor passed his water, and, as far as I could gather, there had been no convulsive movements. These attacks came on while he was quite quiet and making no exertion of any kind. He also suffered from vertigo and had attacks of syncope while in bed.

His general appearance is that of a strongly-built, vigorous, and very healthy-looking man. Before he became subject to these attacks, he was in the habit of taking a good deal of exercise—walking ten miles a day in addition to his work as a carpenter, which was rather of a skilled nature, not involving severe manual labour. There is no history of lues, and as regards alcohol he has been very moderate. He has, however, been a heavy smoker of late years. Up to the age of forty he had been quite moderate in this respect, but he then began to smoke about one ounce per diem of best shag, though for a few months before I saw him he had reduced this. He has also been a large meat-eater.

He came into the hospital for six weeks (February to March, 1904), and improved very much as regards his symptoms. The pulse-rate varied between a minimum of twenty-six and a maximum of thirty-six at different times, but was always regular; it did not appear to be accelerated by position, stimulation, or exercise. Sphygmographic tracings showed a slow pulse and nothing more. While in the hospital a soft, blowing systolic murmur developed, limited to the apex. He had several fainting attacks, being unconscious from ten to twenty seconds, and on two of these occasions the limbs were observed to twitch, but there was no alteration in the pulse-rate. The urine showed no trace of albumin, the optic discs were healthy, no signs of arterio-sclerosis, the lungs were slightly emphysematous, and the temperature was subnormal.

throughout his stay in the hospital. For the last ten months he has been much better in every way, having no cardiac pains or vertigo, and very little flatulence; he has only had three syncopal attacks, and has been able to do his work in moderation. The systolic murmur at the apex has, however, become more pronounced, and is now traceable into the axilla. The pulse continues to be regular and the rate is usually thirty when he comes up to my out-patient department.

As regards treatment, I have reduced his tobacco to one pipe a day, and also cut down the amount of meat he was taking. He seems to derive benefit from moderate doses of strophanthus, and for some months has been having

Tinct. strophanthi, 7min.;
Sp. ammon. aromat., $\frac{1}{4}$ drms.;
Aq. ad. 1 oz.;

t.d.s., together with an occasional dose of a carminative mixture for attacks of flatulence.

The question, of course, arises as to the nature of this condition of things. At first I was inclined to regard the case as being due to his excessive tobacco-smoking, as resembling, in fact, those cases described (a) by Sir Lauder Brunton, in which over-smoking is shown in sudden faintness. "The man falls as if he were shot." He considers that this symptom only occurs among those who smoke the better class tobaccos, and I am not sure if "best shag" comes under that category. Though tobacco is known to stimulate the vagus, and so to give rise to a slow pulse, yet, when it does affect the pulse at all, my belief is that some irregularity is always produced, as well as reduction of the rate. Now, in this case irregularity of the pulse has been most strikingly absent. In many respects the case resembles that curious symptom-complex known as "Stokes-Adams" disease. Thus there are:

1. The slow pulse specially characterised by being unaffected by exercise or diffusible stimulants.
2. Vertigo, which occurs as much in the recumbent as in the upright position.
3. Syncope lasting for a few seconds.
4. Slight epileptiform convulsions.

This is perhaps the most characteristic feature of the condition. In my case there were the two syncopal attacks in the hospital, during which twitchings of the limbs were observed; and as, according to Babcock, (b) the convulsive movements may be no more than a twitching of the mouth, they would naturally have escaped the notice of an unskilled observer, hence, I was never able to obtain any history of convulsive movements in the attacks while he was an out-patient. As an objection to this view, it may be urged that in my case the pulse was not appreciably diminished in rate during the syncopal attacks, as is usually the case in Stokes-Adams disease, but the very short duration of the attack made this point difficult of exact observation.

With regard to the rather sudden appearance of an apical systolic murmur, I do not feel prepared with any adequate explanation; it is well known that patients who have had a cardiac murmur during life have, after death, in Stokes-Adams disease, been found quite free from any cardiac lesion.

Stokes himself, however, believed that in these cases there was always fatty degeneration of the heart. While this view as to the pathology is held by some, others regard it as a pure neurosis, while in a few instances lesions of the vagus and cardiac plexus have been discovered *post-mortem*. The prognosis of Stokes-Adams disease is bad, death occurring suddenly in one of the syncopal attacks; the prognosis in my case would have, therefore, to be rather guarded, in spite of the apparent general improvement of the patient's condition.

(a) "The Action of Medicines," Sir Lauder Brunton, p. 322.
(b) Babcock, "Diseases of the Heart," p. 632.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON.

MEETING HELD FEBRUARY 24TH, 1905.

The President, DR. FREDERICK TAYLOR, in the Chair.

DR. J. H. BRYANT showed a case of Anæmia Splenica with marked Pigmentation and Clubbing of the Fingers. The man, æt. 48, temperate, who had never been abroad, had had in July, 1876, a severe fall, and was struck on the left side of his abdomen. In 1900 he suffered acute abdominal pain, and was told that he had an enlarged spleen. In January, 1894, a severe attack of abdominal pain was accompanied by hæmatemesis. He had a yellowish-brown complexion, his fingers were markedly clubbed; he said they had been so as long as he could remember; the spleen was enlarged and extended two inches below the umbilicus; there were numerous patches of dark brown pigmentation in the skin over the dorsum of the foot and front of the legs; the urine was normal; red blood corpuscles 4,350,000 per c.mm., hæmoglobin 70 per cent., colour index 0.8, white blood corpuscles 4,375 per c.mm.

DR. WILFRED HARRIS asked whether Dr. Bryant drew any distinction between cases of splenic anæmia presenting pigmentation and clubbing of the fingers, and those not presenting these symptoms.

DR. TAYLOR referred to a case of splenomegaly with hepatic cirrhosis and jaundice that he had shown before this Society some years ago. That case had pigmentation, large spleen, and clubbed fingers, so resembling the case now shown, save for the cirrhosis.

DR. WALTER SPENCER referred to the good result that had been obtained abroad after splenectomy in these cases. The operation was an easy one if no adhesions were present.

DR. PARKES WEBER thought that the primary lesion in this case was a vascular defect, as the pigmentation was clearly the result of cutaneous hæmorrhages. In some of these cases the enlargement of the spleen turned out to be due to thrombosis of its vessels.

DR. PHEAR did not consider splenic anæmia a suitable name for the case, as no anæmia was present.

DR. BRYANT, in reply, referred to Osler's recent monograph in which Banti's disease was shown to be a terminal stage of splenic anæmia. He did not advise splenectomy on account of the great tendency to hæmorrhages exhibited by the patient.

MR. EDRED M. CORNER showed a case of Dislocation of the Atlas from the Axis, with Fracture of the Anterior Arch of the Atlas. The man, æt. 21, had fallen off a horse upon his forehead. He "saw stars," but was able to mount and ride home. A fortnight later the patient's neck was found to be rigid, and he carried his head a little flexed and turned to the right. He had a difficulty in opening his mouth, also in articulation and in mastication, but not in swallowing. The left transverse process could be felt between the mastoid process and the angle of the jaw; as to the process on the right side the examining finger found in its place a depression, whilst at the back of the pharynx on the right side there was a prominence. A skiagraph showed the dislocation of the atlas from the axis on the right side, and also a fracture of the anterior arch of the atlas. The condition of the odontoid process was doubtful.

DR. PURVES STEWART showed a case of Narcolepsy and Hysterical Blindness. The man, æt. 22, previously healthy, had had an attack of influenza six weeks ago. A fortnight ago he complained of pain in the left side of the chest, but there were no abnormal physical signs, and he had insomnia for four or five nights. He was then given fifteen grains of sulphonal, and slept for nineteen hours continuously. Since then he had had attacks of sudden sleep, occurring at meals, during games, &c., lasting several hours at a time. Four days before admission he developed convulsive phenomena (opisthotonos, &c.) just before waking. Three days

before admission he awoke to find himself practically blind. He could now only distinguish light from darkness, and the gait was that of a blind man. He kept the eyes directed habitually straight forward. Optic discs, pupils, and cranial nerves normal. No headache nor vomiting. Urine normal.

Dr. ALEXANDER MORISON thought that hypnolepsy would be a better term in this case than narcolepsy. Some degree of cyanosis was usually associated with the condition, and they often terminated fatally.

Dr. PURVES STEWART, in reply, justified the term, which was invented by Charcot. The interesting part of the case was the blindness. This was not always present and differed from organic blindness in that the patient did not attempt to look in the direction of the person speaking to him, but kept his head fixed.

Mr. A. H. TUBBY showed a case three years after Muscle-grafting for Paralysis of the Left Upper Extremity. In June, 1901, the boy, then *æt.* 7, had had infantile spastic paralysis of the left upper extremity from birth. The forearm and hand were in the position of excessive pronation, with flexion at the elbow and wrist. The fingers were strongly flexed. The pronator radii teres was detached, then passed behind the radius and re-attached so as to act as a supinator. The palmaris longus and other flexor tendons at the wrist were divided. The patient had regained extension at the elbow, supination of the forearm, and flexion and extension of the fingers, especially when the humerus was fixed.

Dr. FARQUHAR BUZZARD did not think that there was any evidence that muscle-grafting had done any good, as the tenotomy might account for any improvement that had occurred. The child could even now only supinate to the mid-position, and this was brought about purely by the biceps.

Dr. WILFRED HARRIS asked whether massage had been tried before the operation. If it had only been used since, it may have been largely responsible for the improvement.

Mr. DOUGLAS DREW asked as to the state of the supinator brevis at the time of the operation.

Mr. TUBBY, in reply, claimed that great improvement had taken place on the original condition. The supinator brevis had not been examined.

Mr. WILLIAM TURNER showed a case of Primary Sore on the Eyelid of a Child. The girl, *æt.* 3, had been quite well until early in January, when, without obvious cause, a pimple formed on the margin of the right lower eyelid towards the outer side, and had since steadily enlarged. An enlargement of the glands below the jaw on the right side had been first noticed on February 11th, and there had since been a steady increase in size. The child had seemed ill since February 18th. It had been sleeping with its mother. The mother, *æt.* 29, had had several living children, two born alive, who died after a few weeks, and one miscarriage. She had been under treatment in August, 1904, for secondary lesions, mucous patches in the throat with enlarged glands, and an eruption on the hand.

Mr. CAMPBELL WILLIAMS pointed out that acquired syphilis was of worse import to a child than congenital syphilis, perhaps because the latter cases were armed with maternal antitoxins. In this case he advised inunction rather than internal medication. Extra-genital chancres were usually atypical.

Mr. TURNER, in reply, said that he intended to treat the case with Hydrarg. c. creta, but would use inunction if that failed.

Dr. J. G. SLADE showed a case of Lymphatic Leukæmia with Microscopic Specimens of the Blood, showing an enormously increased number of White Blood Corpuscles. The patient, a house painter, *æt.* 49, had been in hospital under Dr. Allchin. He had always been a teetotaller, without venereal history, and was a moderate smoker. He began to complain, in the autumn of 1902, of weakness and pains all over, and lumps in the neck were first noticed by his wife. In May, 1903, a doctor found lumps in the neck, axillæ, and groins, larger than they are now. He

improved under treatment, but before admission lost flesh, was short-winded, and his face became yellowish. He had had no bleeding nor diarrhoea, nor oedema of the ankles. He was found to have enlarged glands, supra-clavicular, axillary, and inguinal; they were soft, discrete, movable, and not tender. The liver extended two inches below the costal margin, the spleen was enlarged, extending two inches below the umbilicus, and the notch could be felt. His urine had a trace of albumin. Blood examination, February 21st, red corpuscles, 2,430,000; hæmoglobin, 24 per cent.; white corpuscles, 1,300,000; small lymphocytes, 96 per cent.; large hyaline corpuscles, 3 per cent.; polymorphic, 1 per cent.; of the polymorphic 5 corpuscles were finely granular to 1 coarsely granular; blood platelets scanty.

Dr. PHEAR pointed out that the polymorphonuclear cells, which composed 1 per cent. of the leucocytes, were relatively diminished, but absolutely these were increased nearly three-fold.

Dr. PARKES WEBER commented on the low colour index, 0.5, which was rare in leukæmia.

Dr. TAYLOR speculated on the date of onset of the leukæmia. Large glands had been present several months before the blood had been examined.

Dr. SLADE replied.

Mr. BATTLE showed a case of a man, *æt.* 37, who had swollen knee-joints. The swelling dated from an acute attack in the elbows, knees, and ankles three years ago. The diagnosis was doubtful.

Mr. CAMPBELL WILLIAMS thought that the case was of syphilitic origin, though gout, rheumatism and tubercle had to be considered.

Mr. DOUGLAS DREW showed a girl, *æt.* 7, showing Complete Restoration of Function after Arthrectomy of the Knee-joint. Arthrectomy was performed in September, 1904, for tuberculous synovitis, which had started after a fall two years before. The whole of the synovial membrane was studded with small tubercles. The sutures were removed a week after the operation, and five days later a daily movement of the joint was commenced. A month afterwards some adhesions, which limited movement, were broken down under an anæsthetic. All swelling subsided, and the child had been running about for some months with full movement.

Dr. DOUGLAS DREW also showed a Girl, after excision of the Navicular for Tuberculous Disease.

Mr. KELLOCK said that the result in the first case was so wonderful that he was forced to doubt the original diagnosis. The tibiæ were thickened and curved as in congenital syphilis. The appearance of the synovial membrane in syphilis might mimic tubercle closely.

Mr. DREW, in reply, had no hesitation in saying that the case was tuberculous. He found no evidence of syphilis. He was himself astonished at the result seeing that, not wishing to cut the crucial ligaments, he had left some tuberculous material behind. The disease was only in the superficial layers of the membrane. The good result was due to the chronicity of the lesion.

Mr. J. HUTCHINSON, jun., showed a case of Ossifying Sarcoma of the Fibula. The patient, a man, *æt.* 35, had observed the tumour during the last two years. It overlapped the tibia, and extended from a hand's-breadth below the knee to the lower third of the leg. The radiograph proved that it grew from the fibula alone, and that there was a large amount of bone towards its centre. It interfered but little with the muscles of the limb, but had caused a certain amount of pain. Pulsation in both anterior and posterior tibial arteries did not seem to be altered at the ankle. The patient had sustained no injury to the part and no other cause could be assigned for the development of the tumour.

Dr. EASTES pointed out that clinical examination seemed to show that the growths proceeded from the tibia, while the radiograph clearly proved that it came from the fibula.

Mr. KELLOCK did not think it made any difference

where the growth came from, as it had crept so far round the limb that amputation at the knee was necessary. He was surprised that Mr. Hutchinson intended only removing the fibula, and feared that the posterior tibial vessels and nerve would of necessity be injured.

Mr. DOUGLAS DREW quite agreed with Mr. Kellock as to the line of treatment. Even when early and high amputation was done in these cases, the prognosis was very bad, death invariably occurring in under a year.

ROYAL ACADEMY OF MEDICINE IN IRELAND. SECTION OF STATE MEDICINE.

MEETING HELD FRIDAY, FEBRUARY 10TH, 1905.

The President, SIR JOHN W. MOORE, in the Chair.

EARTH-TEMPERATURE AND DIARRHOEAL DISEASES IN DUBLIN DURING 1904.

THE PRESIDENT read a paper on this topic. Having quoted the late Dr. Edward Ballard's views on the relation between a critical temperature of 56° F. at four feet below the surface of the ground and an epidemic mortality from diarrhoeal diseases in late summer and early autumn, the author of the paper submitted and explained two diagrams showing a comparison between the death-curve from diarrhoeal diseases in the Dublin registration area during the summer and autumn of 1904, and the earth-temperature records from the Normal Climatological Station, which was established within the precincts of the University of Dublin by the Provost and Senior Fellows of Trinity College on January 1st, 1904. The diagrams show that in 1904 diarrhoeal mortality was trifling till the week ended August 6th—that is, the third week after the subsoil temperature at four feet had passed above 56° F. The mortality increased week by week, until 35 deaths from diarrhoeal diseases were registered in the week ended August 27th—that is, about 10 per cent. of all the deaths from those diseases (339) registered in the course of the whole year 1904. This maximum of mortality followed the maximum of warmth of the soil at four feet (58.5° F.) by an interval of just a fortnight. Such a coincidence is at least remarkable, and may be turned to practical account as a warning that diarrhoeal diseases are about to become rife whenever the earth thermometer at four feet rises to 56°.

Dr. KIRKPATRICK said that the chief interest and value of the observations was to give an indication of the onset of these attacks of summer diarrhoea in children to the authorities, who could then take precautionary measures, and give timely warning of its approach. This was possible, owing to the interval which elapsed between the rise of the earth-temperature to the critical line of 56° and the incidence of the diarrhoea. He did not think there was sufficient evidence to show that the rise of the temperature to the critical line and the summer diarrhoea were connected causally. It was more probable that the earth-temperature reached a certain height only during conditions when epidemic diarrhoea was liable to arise also, and there was probably an organism which could develop when the earth-temperature had been a sufficient height for a certain length of time. This was borne out by the fact that the mortality from summer diarrhoea was much less among breast-fed than bottle-fed children, and everyone knew the difficulty of giving bottle-fed children even moderately sterile food. There could be no doubt that this epidemic diarrhoea was started by the introduction of poisonous food into children, and it was probably caused by organisms capable of producing decomposition in foodstuffs, and not by any specific bacillus. He hoped that active measures would be taken next year to prevent the onset of summer diarrhoea, and warning given in time to take due precautions.

Dr. CRAIG was sure that Sir John W. Moore did not mean to convey that the earth-temperature alone caused this epidemic diarrhoea. It was only lately

that physicians had recognised that this very fatal affection was due to micro-organisms. He thought that the heightened temperature tended to increase putrefaction, and that flies had a great deal to do with carrying the infection. People who were careful with regard to their food were rarely affected with summer diarrhoea. He thought that children used often to be affected through the state of the bottles themselves.

Dr. M'VITTIE said he would like to have an explanation of the statement that diarrhoeal diseases were more markedly on the increase in those districts where the houses were closely built than where there was an excess of population. This would indicate that the earth-temperature could not be the main factor because a large portion of earth covered by closely-built houses could not rise to the same temperature as places where there was a lot of open space between the houses. Closely-built houses maintained a more equable earth-temperature in summer and winter. Therefore there must be a number of other factors in the causation of these diseases, such as increase of fruit supply, &c. Another factor was that young people in cities became exhausted at that time of year, and their capacities for mastering those diseases lowered. Small children played a lot in the sun, got into heats, and then got chilled.

Dr. LANGFORD SYMES thought that those who suggested that there was a multiple series of factors producing those diseases held the correct view. These diseases seemed to destroy more children than adults, and, perhaps, a milk diet accounted for that. We seemed to be more exempt from them in Ireland than in other places, such as New York, where the infant death-rate was much higher. The climate here seemed to minimise them, there being no great difference between the summer and winter temperatures in Dublin. The earth-temperature certainly seemed to have a great deal to do with the development of the organisms which caused the diseases and predicts their onset. As to food, it was found by Holt that this factor greatly influenced their onset among infants. The ground had recently been gone over again in America by bacteriologists, and they had come to the conclusion that not only the earth-temperature, but also food, had a good deal to say to their causation. Again, Holt had noticed in his series seven cases of breast-fed infants who had also got water from the tap without boiling, and the seven had died; therefore the diseases might be water-borne. Another factor was sanitation, and, indeed, these diseases used to be taken as a sanitary index. With regard to infection, light had been recently thrown on this question by Shiga in Japan, who had found a bacillus which gave the Widal and Pfeiffer reactions with blood serum, and which he considered to be the specific bacillus of the diseases. It was called the *Bacillus dysenteriae* of Shiga. Besides this bacillus there was also the Flexner-Harris type, which was found principally in the mucous portions of the stools, and in scrapings from the mucosa after death. An acid medium was necessary for their growth, and we knew that many children's foods developed acidity, which might account for their ready growth. A serum had been made from horses, and injected in these cases, but it had not proved to have much value. He thought that Dr. Craig had struck a good note in referring to flies, insects, &c., as a means of conveying serious infection.

Dr. MATSON asked Sir John William Moore if he thought the nature of the ground had anything to do with those diseases. He himself, whilst in a London hospital, had seen a severe epidemic and had gone from that to Hampshire, where a similar epidemic occurred. The soils in the two places were very different. The following year, whilst in Las Palmas, where the temperature was 80° to 85°, he asked a doctor there what his experience of those diseases was. He told him that he had never seen them in children nursed by their mothers, whilst there was a considerable amount of fatal diarrhoea among older children, who were liable to infection from fruit, garbage, &c.

Dr. WINTER said that Sir John spoke of a heavy rain-

fall seeming to have been followed by a decline in the death-rate. While in England, twelve years ago, he himself had had occasion to examine the reports on the Tees Valley epidemic of enteric fever, and a heavy rainfall there was followed by a great increase in the number of cases. If these two facts were correct, he would say that enteric was water-borne, and these diarrhoeal diseases were not water-borne, but were carried through the air contaminating the food.

Dr. NINIAN FALKNER said he would like to call attention to the nomenclature of these so-called diarrhoeal diseases. Some years ago, statisticians found a lot of cases returned as gastro-enteritis, enteritis, and mucocenteritis, and it soon became evident that these terms were loosely used. A special committee was appointed, the net result of whose labours was that these three divisions were all placed among the local diseases of the digestive system.

Sir JOHN WILLIAM MOORE, in replying to Dr. Kirkpatrick, said that last year the observations had been used to give warning of the onset of diarrhoeal diseases. He had been careful in his paper not to commit himself to saying that the earth-temperature was the absolute cause of these diseases, but said it was a remarkable coincidence. He agreed that various organisms might cause the diarrhoea. A very interesting point was, that the symptoms were referable to poisoning of the centres in the medulla oblongata. He also agreed with Dr. Craig as to the mischief caused by flies, and thought that this was very far-reaching. He believed that small-pox infection had often been carried by them. He could not quite agree with Dr. M'Vittie that the mere placing of houses over the soil would very materially interfere with the rise of the subsoil temperature. With regard to Dr. Symes' observations, he said that everyone agreed that food was of extreme importance. With regard to the nature of the soil he said that clayey soil always warmed up more slowly than gravel or sand, so that diarrhoeal diseases might be expected earlier in the latter case. With regard to what Dr. Winter had said, he thought that the mortality had been checked last year by heavy rains, this going in favour of contamination by dust or flies.

A short paper on "Sicily as a Winter Health Resort" was then communicated by Dr. PARLATO, of Palermo.

HARVEIAN SOCIETY OF LONDON.

MEETING HELD FEBRUARY 9TH, 1905.

Dr. G. A. SUTHERLAND read a paper on
LOBAR PNEUMONIA IN CHILDREN.

He referred to the valuable information to be obtained by a study of the child's expression and breathing. The expression of the face was much more placid in lobar pneumonia than in catarrhal pneumonia, owing to the obstruction conditions present in the latter. The breathing in lobar pneumonia was rapid, superficial, and often of inverted respiratory type. The increased movement of the *alæ nasi* usually consisted of an expiratory and not an inspiratory dilatation, and was due to forcible expiration. He reviewed the clinical symptoms of three leading types of pneumonia, the cerebral, the gastro-intestinal, and the renal, in which all through the disease the pulmonary condition might remain unsuspected. Renal cases might present as the leading symptom hæmaturia or general dropsy. The treatment in ordinary cases was practically that of a specific fever. Coughing, fever, sleeplessness and pain were symptoms which might call for treatment. As a rule the pre-critical stage was the period of greatest severity, and cardiac tonics and leeching were the best remedies at this time.

Dr. GUTHRIE thought that lobar pneumonia was better recognised now, being less fatal than bronchopneumonia. He thought the facies were anxious, not apathetic and placid—the breath being held on account of pain. He believed central pneumonia with distant tubular breathing occasionally occurred. He

remarked on pseudo-crises. Strychnine should be pushed where required.

Dr. JAMES TAYLOR also thought the expression was mostly anxious. Digitalis when given should be started early in the disease. Empyema was more common after lobar pneumonia than after the catarrhal form.

Dr. ALEX. MORISON thought the fever should be treated if high, and not allowed to run riot, as it affected the circulatory system. Ice to the head was soothing and a useful antipyretic. Bleeding was at times useful at the onset. He also thought strychnine was a drug that should be pushed when needed. Digitalis he did not use. Turpentine is useful when there is much secretion in the tubes.

Dr. CAUTLEY was accustomed to differentiate between children and infants in speaking of pneumonia in childhood. One should always remember the possibility of otitis media as a complication, often unaccompanied with pain. Bleeding in children was rarely necessary, and he doubted the advantage of using the ice-bag.

Dr. SUTHERLAND replied.

Mr. LAMING EVANS read a paper on

ANTERIOR METATARSALGIA.

with notes on seven cases. In reviewing the literature of the subject he drew attention to the fact that Morton and Bradford had described the disease in feet otherwise normal, whereas R. Jones had found twelve out of fifteen cases with flat-foot also; that Morton and Jones had resected in the majority of the cases, whereas Bradford, Gibney, and Poldthwait stated that the operation was never necessary. An analysis of these seven cases showed that the fourth metatarso-phalangeal joint was affected in all and the third in two cases. All the cases occurred in women, six in private and one in hospital practice, in this agreeing with all previous records. Neither injury, nor sudden onset, nor rupture of the transverse ligament were present. The longitudinal arch was depressed in three cases, and the transverse arch in three. The fashionable narrow pointed shoe was considered responsible for an aggravation of the mischief, if not the actual cause of it. Five of these cases had been dealt with by palliative measures, with partial relief of symptoms, and two by excision of the head and neck of the fourth metatarsal bone with complete removal of the pain, and with a sound functional foot, without any weakening. He advocated that palliative measures should be tried in the first instance, but if these failed, that removal of the head of the metatarsal bone should be performed with a good chance of curing the disease, and without fear of weakening the foot.

Mr. JACKSON CLARKE had not operated on these cases during the last five years. The general health should be improved and much attention paid to shoes. He advocated the use of steel plates in the boots, carefully made after taking a plaster mould or model of the foot. Metatarsalgia was often a symptom of flat-foot. Patients were often markedly irritable with this condition.

ULSTER MEDICAL SOCIETY.

MEETING HELD IN THE MEDICAL INSTITUTE, BELFAST, ON THURSDAY AFTERNOON, FEBRUARY 16TH.

The meeting was a new departure, consisting of a clinical demonstration of interesting cases, no papers or notes being read. The cases on the agenda paper numbered 34, but several more were brought, so that ample material for the demonstration was forthcoming. The attendance of members was large, including many country members, who cannot conveniently come to the evening meetings, and all agreed that the new departure was most successful, and should be repeated.

The PRESIDENT (Dr. William Calwell) showed (a) A case of Angio-neurotic Edema, and (b) Some Illustrations of Skin Diseases.

Professor LINDSAY showed a case of Acromegaly, with photographs.

Dr. ST. GEORGE showed (a) a case of Pernicious Anæmia, and (b) a case of Syphilitic Ataxia.

Professor Sir WILLIAM WHITLA showed (a) a case of

Lead Palsy, and (b) a case of Paralysis Agitans. The gait in the second case was most typical and interesting.

Dr. CECIL SHAW showed (a) a case of supposed Malignant Growth at the outer side of the eye in a boy *æt.* 5. The case came under his notice five weeks before, with a history of a conjunctival catarrh, following a supposed blow on the eye a fortnight earlier. The eye was examined under an anæsthetic, but nothing could be found except a slight purulent conjunctivitis, with granulation tissue at the outer canthus. In the last fortnight this had increased, and marked swelling at the outer side of the eye had arisen, apparently in the bone, rendering a diagnosis of malignant disease at least probable. (b) A case of Sudden Amaurosis after Influenza. Vision began to fail the second day of a slight attack of influenza in a healthy young man, *æt.* 20, and in three days was reduced to counting fingers at a foot in the right eye, and *nil* in the left. Taste was also lost, but recovered in a few days. There was no headache or vomiting, the discs were normal and the pupils dilated. The patient had been under observation just six days; no improvement had taken place, nor had any other symptoms shown themselves, and a provisional diagnosis of toxic amaurosis caused by influenza had been made.

Mr. A. B. MITCHELL showed five cases:—(a) A case of Tumour of the Upper Jaw. The tumour in this case was an epithelioma simulating an epulis. (b) A case of Club-Foot after operation. (c) A case of Necrosis of the Skull. The interest of this case lay in the fact that it was an extensive necrosis of tuberculous origin occurring in a patient, the subject of hereditary syphilis. (d) A case of Removal of both Pectorals. Removal of both pectorals had been carried out in this patient for a large carcinoma of the breast. Three weeks after operation, a very free range of movement was preserved. (e) A case for diagnosis.

Dr. JOHN McLEISH showed a Cerebral Case for diagnosis. The patient was an ex-soldier, a man of about 45, with a history of syphilis. His present illness began about three years ago, with headache, vomiting, and almost complete right hemiplegia. At the present time the hemiplegia is practically well, but he has complete double optic atrophy, apparently primary, occasional headache referred to the back of the head (not nearly so severe as formerly), occasional nausea, especially when suffering from constipation, and occasional convulsions of the Jacksonian epilepsy type, beginning in the right hand and extending up the arm. The probable diagnosis is a gumma about the hand motor area, or possibly an exostosis of syphilitic origin.

Dr. THOMAS HOUSTON showed a case of Acne of the Face treated by injections of sterilised staphylococci, after the method of Professor A. E. Wright. The affection had been fairly severe for a year, and now after three injections the face was almost clear.

Mr. ROBERT CAMPBELL showed eight cases. (a) A case of Congenital Deformity of Hand and Forearm, combined with Obstetrical Paralysis of the Face. The patient was a child of 13 months, in whom the left forearm and hand were imperfectly developed, the hand being flexed. The obstetrical paralysis of the face, which had no connection with the imperfect development, had persisted unchanged. (b) A case of large simple Meningocele successfully excised. (c) A Meningo-myelocele complicated with a nævoid lipoma, also excised. (d) A patient who had had a large Congenital Hairy Mole, covering half the forehead, the left temple, and the parotid region of the left cheek. It was completely excised, and immediate skin-grafting by Thiersch's method carried out. The result was very good. (e) A boy, *æt.* 3, who had been the subject of three abdominal sections in less than two years, two for intussusception and one for the radical cure of hernia. (f) A case from which a large Hydrencephalocele was excised six years ago. The tumour, which was one and a half times the size of the child's head, was formed by the posterior end of the right lateral ventricle. It was removed at the age of three weeks, and its removal necessitated the removal of the right occipital lobe.

The child is now six, and cannot walk without help. He can only say a few words, but can understand all that is said to him. There is hemi-atrophy of both discs. (g) A case of Deformity of the Elbow, resulting from a fracture of the humerus. The fracture involved the external condyle, with displacement downwards, producing marked gun-stock deformity when the arm was extended. (h) A case of Ankylosis of the Temporo-maxillary Joint. This occurred in a boy, *æt.* 8, as the result of a crush between two wagons. Attempts to remedy the condition by forcible separation with a gag failed, and Mr. Campbell had removed both condyles three weeks ago, with the result that the boy had now almost perfect restoration of movement.

Mr. JAMES CRAIG showed two similar cases of Imperfect Development of the Eyes, occurring in sisters. These children were aged about 10 and 8, and both had aniridia, unilateral in the elder and bilateral in the younger. There was as well an irregular nystagmus, with very defective vision. The children showed no sign of mental defect.

Dr. J. C. RANKIN showed (a) Two cases of Lupus treated by Röntgen Rays, and (b) Two cases of Lupus treated by Finsen Light.

Dr. J. R. DAVISON showed a curious skin case for diagnosis.

Dr. MCKISACK showed (a) a case of Locomotor Ataxy in a young subject, and (b) a case of Paralysis Agitans.

Mr. ANDREW FULLERTON showed (a) a case of Simple Ulcer of the Bladder, successfully treated by Suprapubic Cystotomy. (b) A boy with a testicle in the perinæum. (c) A case of Papillomatous Synovitis of both Knee-joints, successfully treated by partial erosion.

LIVERPOOL MEDICAL INSTITUTION. MEETING HELD FEBRUARY 16TH, 1905.

Dr. JAMES BARR, the President, in the Chair.

MR. RICHARD WILLIAMS exhibited and demonstrated the particular advantages of a modified eye speculum.

Drs. T. R. and E. E. GLYNN related a case of
INTERNAL HYDROCEPHALUS

in which the symptoms simulated those of intracranial tumour. The patient received a blow on the head in 1898, which caused temporary loss of consciousness. Gradually symptoms of cerebral tumour developed, and these symptoms continued until June, 1903, when clear fluid commenced to flow from the right nostril and very soon improvement set in, followed by complete recovery in the course of a few weeks.

Dr. A. G. GULLAN read notes of two cases of
ADDISON'S DISEASE,

in which he had administered suprarenal extract. In the first case, that of a young man, in whom the symptoms of the disease were well marked, 15 grains of the extract were given thrice daily, but with only temporary relief, the patient dying seven weeks later. At the *post-mortem* examination no signs of tubercle were found except in the suprarenal bodies, which were both enlarged and destroyed by caseous masses, evidently of a tuberculous nature. In the second case, that of a woman, the symptoms were less severe, and she had greatly benefited by taking 20 grains of the extract thrice daily.

Mr. DAMER HARRISSON opened a discussion on
THE UNION OF NERVES AFTER DIVISION.

He gave a short history of the subject—physiological and surgical. The more recent histological observations which support the theory of coalescence and the process of regeneration in the peripheral or of a divided nerve were described, together with the criticisms of Mott, Halliburton and Edmunds. On the physiological side he advanced the view that the weight of evidence was on the side of the outgrowth theory; and brought forward a series of observations made by himself and Professor Gotch, after division and suture of the sciatic nerve in the rabbit, which proved that sensation reflexes appeared first in the peripheral and nearest

the point of suture, and at later periods, at the more distant points in the peripheral end. With regard to the motor response, this appeared at an earlier date in proportion to the nearness of the division and suture to the muscles. These facts were difficult to explain by means of the coalescence theory, and strongly supported the outgrowth theory.

Dr. ROBERT KENNEDY said that from the clinical point of view there was a well-established observation, which the central theory of regeneration of nerves could not explain, namely, the early return of sensation after secondary suture of a divided nerve. Ranvier's view does not explain this rapid restoration, for in the first place unnaturally rapid growth of new nerve fibres from the central end would be required, as no sensation could be felt until the axis cylinders had reached the end organs. In the second place, there would be a difference of time in the reappearance of sensation accordingly as the section of the nerve was near or far removed from the end organs, which there is not. As regards suture of the nerve immediately after section, sensation takes much longer to appear, and this is what one would expect, as time is required for regeneration of the new fibres in the distal segment. When suture is performed at a time remote from section, the distal segment has had time to form its new nerve fibres. The only difficulty is to explain the very early passage of impulses across the plane of suture, but this is probably brought about by the junction of neurilemma cells newly formed from the central and peripheral ends, the gap being thus bridged, the impulses apparently having the power to pass along the protoplasm of such cells. The reason why motion recovers later than sensation is owing to the rapid degeneration of the muscles after nerve section, which degeneration must first be recovered from. From observations made in the past few years he was of opinion that muscular tissue never completely degenerates, although separated from the nerve centres for long periods. A series of microphotographs were shown illustrating his views of nerve regeneration in the distal segment as opposed to the recent explanation advanced by Langley and Anderson.

Professor SHERRINGTON said he favoured the peripheral rather than the central theory of nerve regeneration, and remarked that after removal of a spinal ganglion, delicate nerve fibres can be found in the portion of the root attached to the cord.

Dr. W. B. WARRINGTON called attention to certain alterations in the nerve cell which took place after section of its axome. In this condition, known as chromatolysis, the cells assume the embryological form in preparation for renewed activity. Chromatolysis occurs in nearly all the cells of the spinal ganglia when the section is made on the peripheral side, but not at all when the posterior root is divided. In the former case the nerve fibres regenerate, but not in the latter. Similarly after section of the anterior root, nearly all the cells of the corresponding segment in the vertebral horn undergo chromatolysis and ultimately repair; but after cutting off the incoming impulses by division of the posterior roots, and thus producing a permanent isolation, some of the cells of the anterior horn atrophy and undergo complete degeneration. It was submitted that these experiments furnish evidence of the important part taken by the cell in the regeneration of a nerve fibre.

Professor J. S. Macdonald and the President also took part in the discussion.

OTOLOGICAL SOCIETY OF THE UNITED KINGDOM.

MEETING HELD MONDAY, FEBRUARY 6TH, 1905.

DR. THOMAS BARR, President, in the Chair.

The Inaugural Address was delivered by the President, which we hope to publish in our next.

Discussion of Mr. Chas. Heath's paper on the RESTORATION OF HEARING AFTER REMOVAL OF THE DRUM AND OSSICLES BY A MODIFICATION OF THE

RADICAL MASTOID OPERATION FOR SUPPURATIVE EAR DISEASE.

Prof. URBAN PRITCHARD said that it was the experience of otologists that the complete post-aural operation in a large proportion of cases was followed by an improvement in the hearing. He, Prof. Pritchard, was afraid that Mr. Heath operated on many cases which would not be considered by most otologists to require operation. He thought the operation described was practically Stacke's operation. He thought it was a pity that the paper was published in the *Lancet* before the discussion on it took place.

Mr. MACLEOD YEARSLEY thought the only novel thing about the operation, which was really Stacke's, was the indiarubber head sheet. He did not think it was possible to ascertain the condition or extent of the antrum by means of bent probes introduced through a small opening, and ridiculed the idea that in 60 per cent. of the cases the whole of that cavity was situated in the pars petrosa. He did not think it necessary to interfere with the stapes, even if it were possible, as Mr. Heath stated, to snip off the crura.

Mr. CHICHELE NOURSE thought any suggestion which tended to shorten the after-treatment of the complete mastoid operation should be welcomed. He thought the real question at issue was whether Mr. Heath's procedure was a step in advance—the question of the selection of cases did not enter into the paper, though he might remind members that Dr. Dench had advocated operating on every case of suppurative otitis media. Mr. Nourse thought the modifications were matters of small detail rather than of principle—the stitching of the meatal flap, the use of the large tubes and spirit drops, all of which were improvements.

Dr. MILLIGAN said that Mr. Heath's paper started from false premisses, *viz.*, that bad results as regards hearing were obtained by the ordinary method of doing the mastoid operation. He thought it was the experience of every otologist that the ordinary operation resulted, in the great majority of cases, in a marked improvement in the hearing. The number of cases operated upon was rather staggering, especially for a throat hospital. In his experience, not more than 4 per cent. of the cases in an aural clinic required the complete operation. Dr. Milligan did not think it was possible to see the "fenestra" without removing a large part of the posterior wall of the meatus, and thought it unlikely that if the greater part of the mucosa were so diseased as to require removal, the portion around the fenestra would be healthy. He complained that no definite data had been supplied to members, as promised, concerning preliminary treatment and duration of the disease.

Mr. C. A. BALLANCE said he felt unable to discuss the paper without having attached to it details of two or three dozen consecutive cases. He did not think any English otologist should write such a paper without reference to the great work which had been done in Germany. With regard to the operation itself, he did not think any but the most limited and slightest form of disease could be removed or even exposed by it. It was claimed that the incision left no disfiguring scar, neither was there a disfiguring scar in the operation performed by him (Mr. Ballance) or his friends. The flap was described by Stacke in 1889; as to restoration of hearing Mr. Heath must be quite unaware of the results of the radical mastoid operation. He (Mr. Ballance) had examined twenty consecutive old cases last year, and in every one found an improvement in hearing, and in some a very remarkable improvement; but he did not claim that his results were exceptional. All his friends got practically the same result. He had no experience of narrowing of the meatus, nor of delayed healing except where it was impossible to remove the whole of the disease.

Mr. FRED. SPICER congratulated Mr. Heath on his results, such results showed that there was no justification for submitting patients to two operations; indeed,

until that evening, he had been under the impression that the grafting operation had long been given up. He himself owed Mr. Heath a debt of gratitude because since he had adopted his methods, the time during which his patients had been under treatment had been reduced by one-half. The question of the selection of cases was not dealt with in the paper.

Dr. H. MACNAUGHTON-JONES thought the question of the selection of cases for operation was of greater importance than the *technique* of the operation. He complained of the absence of trustworthy statistics which Mr. Heath had promised to provide, if possible. They knew nothing of the conditions which preceded the operation. He could not discuss the paper from an operative point of view, but he certainly could discuss it from the aspect of the experience of therapeutics in otology, and he could not conceive of such a condition of things as Mr. Heath had said existed, *i.e.*, that so great a proportion of cases needed operation.

(Mr. ARTHUR CHEATLE moved, and Mr. FAGGE seconded, that the meeting do proceed to the next item on the programme. As other gentlemen wished to speak, the motion was not adopted.)

Dr. PEGLER was sorry at the turn the whole discussion had taken. He asked whether Mr. Ballance would not grant that Mr. Heath took it for granted that members would be fully acquainted with the details of the Schwartz-Stacke operation, and in that way admit that it was not necessary in a short paper to allude to what those magnificent surgeons had done, and without whose work Mr. Heath would probably not be operating as he was? It would be more correct to speak of Mr. Heath's "methods" than of his "operation." He had been struck with the great care Mr. Heath took in the many details of the operation—particularly with the introduction of the rubber meat tube.

(A suggestion by Dr. JOBSON HORNE that the discussion should be adjourned until statistics had been supplied was not seconded.)

The PRESIDENT said it was to be regretted that Mr. Heath had not submitted to them precise scientific details as to the condition of the hearing before and after, the duration of treatment before, and the exact pathological condition present at the operations. Mr. Heath was no doubt an earnest man, anxious to do right; he might have been carried away by his enthusiasm and his paper had suffered from the lack of precise notes of the cases. Mr. Heath had shown some excellent results without packing, but his (the President's) experience was that judicious and careful packing was essential to get a permanently open epithelial-lined cavity.

Mr. CHARLES HEATH replied. The only statistics he could give them were as follows: Average duration of treatment before operation, 13 months; average duration of the disease, 15 years; percentage cases with improved hearing, 84 per cent. A great many patients were so pleased with the improvement in the hearing that they begged him to operate on the second ear when that was affected. His publication of the paper in the *Lancet* before the discussion was not a precedent. The after-treatment lasted from three weeks to three months. None of the cases were operated upon unless they had urgent symptoms or had been waiting six months for admission into hospital. He was not aware that so large a percentage of improved hearing had been obtained before. He did not think the skin grafting method lent itself to improvement in the hearing. The whole of the cavity, including the fenestra, could be seen in his cases without a speculum. He left the mucosa around the fenestra because any interference with it produced scarring and consequent damage to the hearing. He had referred to his operation as a modification of Stacke's. Mr. Ballance had said that he could not do the operation through the incision described. Many men had seen him do it and were satisfied that he had sufficient room. He went straight for the antrum and removed all the disease as was shown by the cases exhibited. He very much regretted not having the statistics asked for,

but he had now given all that were available. He regretted that members had not discussed the methods more, instead of other principles involved.

Dr. MILLIGAN then read notes of TWO CASES OF LABYRINTHINE SUPPURATIVE RECENTLY OPERATED ON, WITH SPECIAL REFERENCE TO THE PATH OF INFECTION.

CASE 1.—Patient, male, *æt.* 37. Left-sided suppurative middle-ear disease of twenty years' duration. Main symptoms: Deep-seated pain in the head, constant tinnitus, increasing deafness, and foetid discharge. Radical mastoid operation; exposure of outer labyrinthine wall; fistula in horizontal semicircular canal; sprouting granulations; enlargement of fistula; subsequent packing. Complete recovery so far as fresh symptoms concerned.

CASE 2.—Patient, male, *æt.* 46. Duration of disease over twenty years. Latterly severe headache, inability to work, constant tinnitus, intermittent attacks of vertigo, sickness, fairly well-marked facial paralysis, profuse foetid discharge from the left ear. Radical mastoid operation; large fistulous track leading through the fenestra ovalis into the vestibule, from which pus oozed; enlargement of the perforation, curetting, subsequent packing. Uninterrupted progress; recovery.

The cases were discussed by Mr. Hugh E. Jones, Dr. Whitehead, Prof. Urban Pritchard, and the President.

Dr. HERBERT TILLEY: Case of Acute Labyrinthine Suppuration in male patient, the subject of chronic otorrhoea. Symptoms: Severe temporal headache and deep-seated earache, slight dizziness, no tinnitus, temperature 102.2°, and general *malaise*. Radical mastoid operation, fistula discharging pus in external semicircular canal; the latter freely opened up and drained. Recovery.

Mr. L. LAWRENCE: Patient suffering from Chronic Non-Supplicative Middle-ear Disease, in whom a mere touching of either tympanic membrane produces marked and rapidly extending hyperæmia. The condition might be called "urticaria of the drum."

The case was discussed by Dr. Edward Law.

Mr. ARTHUR CHEATLE: A few notes on 250 Temporal Bones of all ages, sectioned vertically through the antrum and mastoid process.

Dr. W. H. KELSON: Notes of an Operation performed for Atresia of the Meatus. The patient suffered from deformity and atresia on the left side, and was shown at the December meeting.

Mr. ERNEST WAGGETT showed a patient, and Macro- and Microscopic Specimens and Drawings of a Case of Endothelioma of External Meatus. The tumour was observed in its early development in a man, *æt.* 43, undergoing treatment for another malady. After microscopical diagnosis the entire cartilaginous meatus was removed in April, 1903, and no recurrence has taken place.

The case was discussed by Mr. Arthur Cheate, Dr. Jobson Horne, and Prof. Pritchard, and the specimens were referred to the Pathological Committee.

Dr. PETERS exhibited a Modified Seigle's Magnifying Speculum which can be fitted to a Gruber's speculum.

Mr. RICHARD LAKE read short notes of Two Cases of Deafness secondary to Mumps, and exhibited specimens of Acute Suppurative Otitis in a child, and Chronic Suppurative Otitis in an adult.

Discussed by Mr. Arthur Cheate, Dr. Milligan, Mr. Yearsley, the President, and Mr. Hugh E. Jones.

Mr. HUNTER TOD read notes of a case of Hernia Cerebri et Cerebelli, the result of Acute Encephalitis. Question of treatment. Boy, *æt.* 10. Acute middle-ear symptoms in June, 1904. Paracentesis. Three weeks later admitted to hospital owing to general malaria and pyrexia, although otorrhoea had ceased and middle ear seemed nearly normal. Typhoid suspected at first. No tenderness, redness, nor swelling over mastoid process. Schwartz's operation. Pus in mastoid cells and granulations covering lateral sinus. Jugular vein ligated and lateral sinus freely opened; no thrombosis. Seven days later, owing to rigors,

drowsiness, and headache, cerebellum and temporoparietal lobe partially exposed and explored. Acute encephalitis found, with resulting hernia. Gradual recovery. Hearing now normal on affected side. Hernia covered with hard black crusts; pulsation at edges. Boy otherwise quite well.

Discussed by Dr. Milligan, Mr. Fagge, Mr. Waggett, Mr. Lake, and Dr. Horne.

Dr. MACNAUGHTON-JONES: (1) Drawing of Traumatic Perforation. Caused by blow of hand. The effect on the hearing will be described. (2) Exostosis of the Meatus.

Discussed by Dr. Horne, Dr. Edward Law, Prof. Pritchard, and Mr. Yearsley.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, February 26th, 1905.

HYPERTROPHY OF THE PROSTATE.

HYPERTROPHY of the prostate, says M. Legnen, is a veritable tumour, a kind of adenoma, similar to the adenomata which are found in the mammary gland. But this prostatic tumour, by reason of its position, produces very important modifications in the calibre of the urethra and the neck of the bladder. The two hypertrophied lateral lobes of the prostate produce a flattening of the urethral canal. It is this fact which induced a surgeon to invent a catheter flattened at the extremity, under the idea that it would slide in more easily. Such an instrument is not necessary, for the ordinary catheters succeed very well.

Besides this flattening, the canal is elongated and sometimes considerably so. The development of a median lobe constitutes another factor in the troubles provoked by hypertrophy of the gland. It pushes up the vesical wall, hence elevation of the neck of the bladder and the creation of a depression or *bas fond* in which the urine stagnates and becomes infected. Besides the elevation of the neck, the mucous membrane is thinned out so as to almost efface the wall. All these modifications necessitate a great effort on the part of the bladder, and finally its contractile power is weakened; retention and consequent infection are the result.

The three symptoms of prostatism are dysuria, acute retention, and incomplete retention with distension.

Dysuria.—The patient gets up at night and finds that urine is slow to come and the jet is weak. These accidents are more apparent at night and in the morning than during the day, by reason of the congested condition of the prostate. It can be observed also after fatigue or cold. In such cases the patient should not persist, but walk about a minute, when he will find the urine will come easily. In stricture of the urethra the patient should make an effort to overcome the obstacle. In hypertrophy of the prostate any effort is bad; it only increases the congestion, the cause of all the difficulty in micturition. This dysuria may last for years, it may remain stationary or lead to one of the two remaining complications.

Acute retention is found in men of about sixty years of age after a copious repast or a railway journey. The patient experiences pain, tension, and is unable to relieve himself. Catheterism puts an end to his sufferings and reduces the congestion at the same time. The organ, which was enormous, retracts the following day, as soon as the bladder has been evacuated, in astonishing proportions. This acute retention is not attended with immediately grave consequences. It is a warning of a malady that is commencing. Years may pass before another attack.

Incomplete retention with distension is otherwise grave, for it frequently passes unnoticed. The bladder becomes distended gradually, and no pain warns the patient of the danger. In a few months the bladder is capable of containing a quart or three pints of urine. The patient, instead of having retention, complains of incontinence. He micturates all the time. A patient, *æt.* 65, suffering from incontinence, is almost

certain to be suffering from incomplete retention with distension. He urinates a great quantity, four or five quarts daily from the ureters, and the kidneys are dilated. Signs of urinary intoxication appear: loss of appetite and strength, acute thirst, dry tongue, cachexia—all symptoms which have been more than once ascribed to cancer of the stomach, a regrettable error for the patient.

The only treatment of incomplete retention with distension consists in frequently emptying the *bas fond* of the bladder by catheterism, so as to prevent infection. Sometimes the placing of a catheter *à demeure* for a few days is necessary.

In acute retention, the patients show no cachectic symptoms. They are exposed, however, to hæmorrhage, through false passages created by the catheter from which infection may result.

OXYGEN WATER.

M. Gallois recommends oxygen water as a gastric stimulant in the dose of a teaspoonful in a glass of water. It excites the gastric secretion. In children oxygen water arrests diarrhoea. It can be given in ten drop doses in the milk. Novikoff employs the following prescription:—

Oxygen water, 12 vol., 1 drm.;

Syrup of oranges, $\frac{1}{2}$ oz.;

Water, 2½ ozs.

A tablespoonful every two hours.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, February 26th, 1905.

HR. MENZER, of Halle, has an article in the *Muench med. Woch.*, on

THE ANTISTREPTOCOCCUS SERUM TREATMENT OF ARTICULAR RHEUMATISM.

In his opinion this method of treatment is superior to all others, and for the following reasons: By means of it, disease that has become chronic may be cured, or at least improved; further, by its means acute rheumatism is more readily improved, and especially the chances of recovery in cases of endocarditis are better than by other methods; and, finally, recurrences are better warded off than by other methods, and that even in inveterate cases there is a possibility of considerable improvement.

At the Medical Society, Hr. F. Meyer gave an address on the

CLINICAL EMPLOYMENT OF STREPTOCOCCUS SERUM.

The speaker had exclusively used the serum prepared by himself from human streptococcus.

The action of the serum did not depend on its exciting the body cells to destroy the cocci, but it set free the antitoxin of the cocci and destroyed them in doing so. It had first to be ascertained what quantity was required for use, when was the most favourable time for its use, and lastly in what way was it best introduced into the system.

The clinical use of serum was two-fold—first, prophylactic, to prevent the occurrence of general sepsis when local disease was present, as in severe angina, erysipelas, scarlatina, endocarditis, and, secondly, remedial, when general sepsis was actually present. Generally in the first six hours there was a rise of temperature and symptoms of illness were observed; after two to twenty hours improvement set in and the best result was reached in twenty-four hours. Only seven cases of angina were considered; those with necrosing deposits or grave general symptoms. Both were seen to improve after injection. In septic diphtheria he recommended the injection of Behring's diphtheria serum, as well as his own streptococcus serum. He had the impression that complications such as nephritis were not so frequent with his serum, and that existing albuminuria passed off more readily. Erysipelas was only suitable for injection when it occurred in childhood or in operation cases, when it wandered and was accompanied by grave general symptoms. These cases improved, but one not infrequently saw

large vesicles form after injection; the local inflammation progressed, but without the pulse or temperature getting worse.

In scarlatina the serum had a favourable effect on the fever and the general symptoms, but he had not succeeded in cutting the disease short. His chief aim here was to prevent the outbreak of sepsis. Further observations were required on this point. He confirmed the observation of Bumm as regarded puerperal sepsis. It acted most favourably in cases of puerperal endometritis, quickly leading to the casting off of necrotic patches from the intra-uterine surface, without the onset of severe general symptoms. An injection should be made in cases of slight child-bed fever, and also after important or severe manipulations from which there was danger of infection.

The treatment was contraindicated where the centres of infection were large, and implicated vital organs. Thus in ulcerative endocarditis and disease of serous membranes; it was dangerous also in acute rheumatism and tuberculosis with high fever attributable to mixed infection. On the other hand, a favourable effect was often observed in suppurating carcinoma uteri, although, of course, the original disease was not affected by it.

The bye-effects of injection were neither frequent nor important, at most a local urticaria and a transient numbness in the leg into which the injection was made.

Great dilution of the serum was most advisable, even when large doses are given. More important still was a preliminary injection of physiological solution, and this should be repeated in twenty-four hours. In giving serum the essential point was the prevention of general sepsis. It was not to be expected that cases already going to the bad could be saved.

With his method of treatment, therefore, one should not delay until all other means had been exhausted, but it must be put to use in time.

Hr. H. Aronson denied that all bactericidal sera were alike: with streptococcus serum one was often in time after twenty-four hours; it required living cells to act on the living leucocytes, as Neufeld had shown.

He preferred serum obtained from animals, that from the human subject could not be tested. On the whole, he confirmed the clinical observation, but he did not agree with the contraindication fever. If the treatment was begun early small quantities of serum sufficed.

Hr. Heubner had experimented with serum in scarlatina, and on the assumption that sepsis was secondary had begun early. In spite of this, however, he had not been able to prevent sepsis; on the other hand, during recent periods both with and without the use of serum, he had seen cases recover after suppuration of the glands that he would formerly have looked upon as lost.

These experiences did not encourage further experiment in the case of scarlatina, but this did not show the valuelessness of serum in other forms of sepsis.

He did not look upon the so-called septic diphtheria as a mixed infection, but as a peculiarly severe form of bacillary diphtheria. Any effect from streptococcus serum here was not to be expected.

The discussion was adjourned.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, February 26th, 1905.

LARYNGEAL TUMOURS AND SUNSHINE.

SORGO showed several cases of laryngeal tubercle to the members of the Gesellschaft, which he had treated with perfect success by the rays of the sun. Since 1903, Kunwald had recorded fourteen such cases, which led him to adopt a similar method of treatment. The method is simple, only requiring the use of an ordinary toilet mirror and a throat lens, which the patient can easily be taught to manipulate himself. The toilet mirror is hung in a room where the sun strikes it best; the patient seats himself before it and with his throat mirror can reflect

the rays into the larynx where the tumour infiltration or ulceration is present. Under the influence of the rays the tuberculoma disappears in a very short time, not exceeding twenty applications. One of the cases he presented had suffered from tuberculous thickening of the left cord with tuberculous ulceration, which was now smooth and pliable, after twenty applications. His experience was that the infiltrated forms were more stubborn. He had recently accompanied the treatment by painting the mucous membrane affected with adrenalin in order to increase the specific effect of the rays as the blood seems to retard their action; hence by producing anæmia with the adrenalin the intensity of the rays on the deeper structures is increased. Unfortunately for this form of treatment weather does not permit of an unbroken course, hence the necessity of resorting to artificial light, which Finsen inaugurated and whose rays are probably more parallel with throat affections. In the discussion that followed Lang thought this form of treatment would be better adapted for lupus cases and might be tried. Exner recommended a silver mirror instead of the common glass used by Sorgo.

ESSENTIAL NEPHRITIC HÆMORRHAGE.

Zuckerkindl presented a male patient, æt. 17, who had suffered from what he terms essential nephritic hæmorrhage. According to the young man's history he had suffered for several months before presenting himself at hospital with hæmaturia, which apparently was induced or aggravated by exertion. Six weeks after admission the bleeding was continuous, and by the aid of the cystoscope it was discovered that the hæmorrhage was from the left kidney. To determine whether it was stone or tubercle it was resolved to operate in the lumbar region, using ether as the anæsthetic. After opening the capsule and examining the organ, neither of these morbid conditions were found present, but before closing the wound a small section of the kidney was taken for microscopic purposes. The whole was then closed; the hæmaturia immediately ceased; the patient rapidly recovered, and now is perfectly well. The histological examination under the microscope revealed a condition of glomerulitis proliferans which seems to have been the source of the nephritis hæmorrhagica.

Kapsamer, in the discussion that followed, said that he had performed nephrectomy in three similar cases with perfect recovery. Paltauf said that in such cases the abduction would probably give no indication of an inflammatory condition, and was inclined to disagree with its being a nephritis hæmorrhagica. Albrecht was of opinion that the changes were probably in the pyramid of the kidney or papillæ, which has recently been demonstrated histologically.

FIBROMA WITH SARCOMATOUS DEGENERATION.

Clairmont exhibited a female who had already been operated on three times for myomatous fibroma in the left labium majus. The tumour had now assumed large proportions, and it was his opinion that a radical operation was not likely to meet with any success.

LACTIC SECRETION IN PREGNANCY.

This subject was again reopened by Halban, who affirmed that the phenomenon of puerperal involution was gradual, and that the separation of the placenta immediately checked further physiological progress. He was firmly convinced that the placenta was the determining cause, because the embryo was often found to be dead months before the placenta separated and no lactic secretion discovered, but immediately the placenta is eliminated the milk secretion has been noted to be present. Mandl told us that one of his cases which he depended upon as proving the death of the fœtus as the cause was a mole. Now the separation of a mole is equal to the separating of the placenta, and would thus be proof against his own argument.

Kreidl again repeated his hypothesis, which was opposed to Mandl's, and assured the members that the separation of the placenta was the determining cause of the secretion. Popper said that all these experiments were against Czerny's hypothesis, that a

leucocyte condition was the cause of the colostrum. The opinion of an epithelial colostrum, such as the older authors believed in is now gaining ground.

Foges said that his own experiments were diametrically opposed to the uterus and the ovaries being the cause of the milk secretion. Biologically and mechanically from the distribution of the blood, as Schein has demonstrated, the separation of the placenta is a determining cause of the secretion.

Halban in reply, said he never believed the subject would have assumed such dimensions, but he was firmly persuaded that the death of the embryo or foetus was the real cause of the milk secretion and that the placenta had nothing to do with it.

The Operating Theatres.

ST. THOMAS'S HOSPITAL.

RUPTURED OVARIAN CYST WITH AN INGUINAL HERNIA.—Mr. BATTLE operated on a married woman, *æt.* 60, who had been sent to hospital by Dr. Hallam. She is said to have ruptured herself three years ago in opening a window; the hernia used to go back at night except within a year of admission, when it could be no longer reduced. Some nine months ago she began to get stout round the abdomen; this gradually increased for three months, when she was tapped by a doctor, who drew off, according to the patient's account, twelve quarts of fluid; the fluid soon re-accumulated, and four months afterwards she was again tapped, when about thirteen quarts were drawn off. On examination, when the patient was admitted, the abdomen was markedly swollen below the umbilicus and chiefly in the middle line. A somewhat tense, fluctuating tumour could be felt rising to a point just below the umbilicus, where it had a firm, rounded margin. There was resonance to about an inch below the umbilicus, but dulness in the flanks on dorsal decubitus. The patient had a large inguinal hernia on the right side which was easily reducible. Mr. Battle made an incision over the hernia, the sac was tapped, and a large quantity of pale yellow fluid escaped, after which the abdomen diminished considerably in size. An incision was next made in the middle line below the umbilicus about six inches in length; the large tumour found was brought to the surface and tapped; a thick, darkish-coloured fluid was drawn off, which at first flowed readily, but afterwards, becoming grumous and sticky, did not run through the cannula; but with the assistance of pressure round the tumour the contents were evacuated. After this the pedicle was ligatured and the cyst removed. There was a little difficulty in securing the vessels in the pelvis and a slight quantity of blood was lost. The other ovary was healthy. The tumour was a multilocular ovarian cyst. After the removal of the abdominal tumour, and the cleansing of the peritoneum and removal of all fluid from it, the operation for radical cure was performed by Mr. Battle on the hernia, whilst the house surgeon sutured the abdominal wall. Mr. Battle said that it was interesting to have the combination of the three conditions of ovarian tumour associated with much free fluid in the peritoneum and a distended hernial sac. The presence of the abdominal tumour was unsuspected at the time the first paracentesis abdominis was performed, and it was only after the abdomen had been emptied a second time that the medical man who sent the patient into the hospital discovered a tumour. The question was as to the nature of the fluid; was it ordinary ascitic fluid

or was it fluid which had arisen in consequence of irritation of the peritoneum, caused by the pressure of the tumour, or did it result from rupture of a cyst? The last was thought to be the most likely supposition, and it was thought also that the great distension of the hernial sac pointed to the presence of fluid of a higher specific gravity than ordinary ascitic fluid. At the operation a cyst in the posterior aspect of the main tumour was found to have an opening into it, and this was probably the source of the fluid. The intestines did not return very readily into the pelvis, being collapsed and compressed by the weight of the fluid, which had accumulated chiefly in the pelvis and pressed them upwards, so that a certain amount of air occupied the lower part of the abdomen, when the abdominal wall was closed, which should have been occupied by intestine. In a case of similar character some years ago, which had been described in the Medical Society's "Transactions" by Mr. Battle, the patient had double inguinal hernia, but in consequence of extensive heart disease it was not thought desirable to prolong the operation by doing radical cures of the herniæ; there also the patient had similar compression of intestines, and the pelvis and hernial sacs contained hardly anything but air at the conclusion of the operation, and for three weeks afterwards free air could be demonstrated to be still present, for pressure on the abdomen forced the air into one of the hernial sacs.

The patient made an uninterrupted recovery.

ITALIAN HOSPITAL.

OPERATION FOR THE REMOVAL OF AN ABDOMINAL CYST.—Mr. LENTHAL CHEATLE operated on a woman, *æt.* 45, who had been admitted under the care of Dr. Vincent Dickinson, suffering from a fixed cystic swelling which occupied the hypogastric and left iliac regions, but did not involve the pelvis. There was resonance over the front of it. There was a three years' history of the growth. The patient was a healthy-looking woman; there were no signs of intestinal obstruction. The abdomen was opened in the middle line. The cyst was found behind the sigmoid flexure and between the layers of its meso-colon the external layer of which was dissected off and the cyst enucleated. Its main vascular attachments came from an upward and inward direction, but were not traced to their source. The external layer of the meso-colon was then sewn up again after the enucleation of the cyst and the abdomen closed in the usual way. Mr. Cheatele said he had no idea as to the exact nature of the cyst. He suggested it might possibly be a cystic condition of some embryonic remnant. The cyst contained a fluid of brown colour, and microscopically tufts of papillomatous tissue could be seen. The wall of the cyst was covered by epithelium arranged in a slightly papillomatous manner, that is to say, here and there the epithelial lining was raised into little papillomata. Mr. Cheatele had never seen a cyst of this nature and in this region unconnected with the pelvis and its viscera; this particular cyst, he pointed out, did not pass below the true brim of the pelvis, and had it been allowed to grow it must have caused intestinal obstruction through pressing on the sigmoid flexure. The woman's ovaries, Fallopian tubes, and broad and round ligaments were normal. The cyst was the size of an adult head, contained about a pint and a half of fluid, but no hair.

The patient made an interrupted recovery.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, MARCH 1, 1905.

THE LONDON HOSPITAL FUNDS, THE ORTHOPÆDIC HOSPITALS, AND SCOTCH QUALIFICATIONS.

THE attempts of the Metropolitan Sunday and the King Edward's Hospital Funds to guide, govern and direct the policy of the small hospitals have been on various occasions freely criticised in the columns of THE MEDICAL PRESS AND CIRCULAR. Those attempts have been, in our opinion, ill-advised, chiefly because they have been based on insufficient or wrong apprehension of the issues involved. So far as the orthopædic hospitals are concerned the principle of amalgamation has been insisted upon with apparent disregard of ultimate consequences. In this connection we feel it to be in the public interests unfortunate, to say the least of it, that the Chairman of the National Orthopædic before amalgamation should at the same time have occupied one of the most important honorary posts on one of the Hospital Funds concerned. The National Hospital has gathered £40,000 into its coffers by the sale of the site of the Royal Orthopædic in Oxford Street. That sale took place under the chairmanship of Mr. Harry Marks, M.P. It was opposed by a powerful minority and by two out of the three leading medical journals. That opposition forced up the purchase price by £12,000, and the contention of the opposition is that the valuable freehold site should never have been sold at all, that its value must go on rapidly increasing, and that the site should have been kept as a perpetual endowment in the hands of the charity. Lastly, they claimed that, if sold, its exact value should have been ascertained at public auction in Tokenhouse Yard. Now, the amalgamation scheme approved and advocated by the Funds permits Mr. Marks and his supporters to merge their financial mismanagement in the hotch-potch

of the common chest of the amalgamated hospitals. We claim that the public interests demand an impartial inquiry on the part of the Sunday and the King Edward's Funds before they put their final seal of approval upon the recent policy of the Royal Orthopædic Hospital. We submit that otherwise both these Funds lay themselves open to the suggestion that they may possibly have been made the catspaws of boards of management, the one desirous to hide financial mismanagement, and the other to secure a huge endowment with no particular regard to whether the money involved in the transaction had been acquired by prudent wisdom or by reckless folly. Surely, if the Funds take upon themselves the responsibility of advocating amalgamation of small hospitals, they cannot shrink from the further duty of informing themselves fully as to the issues that are involved in the process. We have in a previous issue (January 18th) referred to the condition imposed by the National Orthopædic excluding surgeons not holding the diploma of an English College. Hitherto Scotch diplomates had been justly and properly admitted to the staff of the Royal Orthopædic, and one of their most distinguished surgeons held that qualification. When amalgamation took place, however, the injustice of the rule at the National Orthopædic was, by private agreement, extended to the "Royal." It is true that one of the surgeons holding a Scotch diploma was permitted to enter the Amalgamated portals, but that was consented to only under the express understanding that, his term of office being nearly completed, his tenancy of the post would be short. Now we ask the Sunday and the King Edward's Funds if they, in advocating amalgamation of the orthopædic hospitals, were alive to the injustice they were inflicting, not only upon certain surgeons, but also upon whole colleges and nationalities. Were they not once again being made the catspaws of men who wished to secure a valuable monopoly in hospital appointments, regardless of the unfairness and injustice thereby inflicted upon holders of Scotch qualifications? As we have asked on former occasions, did the Funds know and not care, or did they not know and not care? Anyway, this monopoly of hospital appointments is unworthy and indefensible, and should be discountenanced by the Funds. What do the Funds propose to do in the case of the City Orthopædic, which they are now pressing to join the amalgamated hospitals? Two distinguished surgeons of the City hospital hold Scotch qualifications; are they to be compelled to abandon their staff appointments at the behest of the surgeons and the Committee of the National Orthopædic, or of the composite orthopædic body formed by the fusion of the Royal and the National Hospitals? We understand on good authority that the Funds have been so far stimulated by our criticisms as to inquire officially whether the National have excluded, and propose to exclude permanently, holders of Scotch qualifications from their

amalgamated medical staff. The public requires information as to this injustice which is being carried on in the charities they support. The Funds, which are supposed to guide the public and are now asserting their right to guide the hospitals, will do well to note the flowing tide of discontent that is gathering against this unjust monopoly of hospital appointments. In many ways we welcome the promise of some sort of central control of the medical charities of the Metropolis. It is well, however, that the movement should be conducted in the light of full information and publicity. We are proud to assume that under no other conditions would the countenance of two good and great members of the reigning house, King Edward and the Prince of Wales, be bestowed upon the Funds which they grace by their personal interest and patronage. But they may be reminded that the colleges of Scotland are Royal no less than those of England.

THE LEGALITY OF COMPANIES FORMED FOR MEDICAL AND DENTAL PRACTICE.

THE Council of the Irish branch of the British Dental Association have earned the sincere gratitude, not only of their professional brethren, but of all members of the medical profession throughout the United Kingdom, for the energy and perseverance with which they have attacked the unregistered practitioners in dental surgery who carry on a fraudulent and, we fear, lucrative trade under the mask of public companies. More than a year ago proceedings were instituted by the Irish branch against a company carrying on business under the name of Jaffé, Surgeon Dentists, Limited, to recover the penalties prescribed by the Dentists Act in the case of persons who, without being registered under the Act, assume a title thereby appropriated to duly qualified and registered dentists. The magistrates before whom the case came refused to convict, and the King's Bench Division decided upon a "case stated" that a corporation or public company was not a "person" within the contemplation of the Act, and might carry on trade under the prohibited titles with absolute impunity so far as any penal consequences were concerned. Undeterred by this reverse, the Council waited until one S. G. Rowell, who perceived the advantages to be gained by forming himself into a company similar to Jaffé, Limited, applied to the Registrar of Joint Stock Companies for a certificate of incorporation of "S. G. Rowell, Surgeon Dentist, Limited." The Board of Trade, to whose notice the facts of Jaffé's case had come, directed the Registrar to withhold for a time the certificate of incorporation. Rowell applied to the King's Bench for a mandamus to compel the Registrar to grant the certificate, and the Council of the Irish branch, by leave of the Court, appeared to show cause against the making of the order sought. The Lord Chief Baron, in a luminous judgment, in which Judges Andrews and Johnson concurred, held that the company had not been formed "for any lawful

purpose," as required by the Companies Acts, that its very name involved a false representation, and that its object was to deceive the public and to defraud registered dentists; the mandamus was accordingly refused, and "S. G. Rowell, Surgeon Dentist, Limited," perished in embryo. The Council had now succeeded, at least, in preventing the formation of any new fraudulent dental companies, but they were not satisfied with that result, and determined to attack those already in existence. Accordingly, proceedings were instituted in the name of the Attorney-General against "Mr. Appleton, Surgeon Dentist, Limited," a company carrying on business in Co. Down, for an injunction to restrain the company from advertising under or using a title calculated to deceive the public, and to compel the directors and shareholders to wind up the company. The case was heard by the Master of the Rolls on February 15th. No defence was filed by the company, which endeavoured to avoid costs by an abortive attempt to commit suicide before the motion for judgment came on for hearing, but two affidavits were put in by the directors, in which they tried to justify the formation of the company under the decision in Jaffé's case. The Master of the Rolls declined to yield to such an argument, and granted an injunction, with costs, not only against the company, but also against the directors, shareholders, and the signatories to the memorandum of association. In the course of this judgment—a perusal of which we commend to the directors and shareholders of similar concerns—he characterised the formation of the company as "an audacious fraud," expressed a clear opinion that the parties concerned in it might have been indicted for a criminal conspiracy, and held that the Attorney-General was fully justified, upon the highest grounds of public policy, in intervening to protect the public "whose health and, possibly, whose lives might be imperilled," by the imposition and fraudulent misrepresentation of unregistered quacks. The justice of his observations is demonstrated by a parliamentary return obtained during the last session on the motion of Sir John Tuke, which shows that no fewer than 89 companies have been registered in the United Kingdom "for dental practice" up to July, 1904, of which twenty-one carry on their trade in Ireland. We commend to the Council of the British Dental Association the example of the Irish branch, and suggest that the latter is deserving of more support and encouragement than it has hitherto received from the General Association in its campaign against illegal competition. We should be glad to see a united effort throughout the kingdom to stamp out a trade as dangerous to the public health as it is injurious to the regularly qualified members of the profession. That this question is of urgent moment to all our professional readers, and subscribers is demonstrated by the return alluded to above, from which it appears that, in addition to eighty-nine dental companies, a large number of companies have recently been formed "for the specific purpose of carrying on medical

practice," and so far as we can see, the decision of Sir Andrew Porter in the Attorney-General *v.* Appleton applies to every company which assumes the distinctive titles of registered medical or surgical practitioners, whether its alleged cures be effected by electricity, magnetism, hypnotism, or humbug, as much as to those which profess the practice of dentistry alone.

Notes on Current Topics.

The London and Counties Medical Protection Society.

THE London and Counties, although not the oldest of the medical defence associations, is to be congratulated on having led the way in the important matter of the accumulation of reserve funds. Last year, 1904, the balance of receipts over expenditure reached the handsome sum of £2,183. It is impossible to doubt that the stability of any organisation of the kind is enormously increased by the possession of a substantial endowment fund. To live, so to speak, from hand to mouth is always to incur a certain amount of risk from unlooked-for emergencies. The work of the Society has been characterised by the usual amount of thoroughness and energy. We are glad to note that the proceedings of Mr. Coroner Troutbeck have not escaped attention. The 1904 report says, regarding him, that "the liveliest indignation continues to be manifested by medical men practising in his district, and cases have been constantly brought under the notice of the Society in which Mr. Troutbeck departs from the recognised usage of coroners. A Committee, appointed by this Society, has been acting in conjunction with the British Medical Association, the Medical Defence Union, and the South-West London Medical Society, and has joined in a protest to the Lord Chancellor on the subject of Mr. Troutbeck's methods. A satisfactory solution of the difficulty has not yet been attained, and the question is receiving the close attention of the Society."

Medical Responsibility in Obstetrical Matters.

At the last meeting of the Central Midwives Board, Miss Wilson, a member of the Board, moved, and Dr. Cullingworth seconded, a resolution to the effect that the secretary of the Central Midwives Board should write to the Local Government Board and ask for a copy of all printed instructions and circulars issued by the Local Government Board dealing with the question of midwifery nurses. It then transpired that the reason Miss Wilson required this information was in order to obtain a circular issued by the Local Government Board, in which it was clearly laid down that the Board recognised the medical officers in infirmaries as responsible in regard to births, midwives being recognised and described as "midwifery nurses." We may be in error in our interpretation of this proposal, but it certainly conveys to us that Miss Wilson is desirous of trying to force the Local Government Board to alter

its regulations so as to make the midwife, and not the medical officer, responsible for the care of parturient women. We can quite understand Miss Wilson bringing forward such a proposition, but the only thing that makes us doubt the correctness of our interpretation of her remarks is that Dr. Cullingworth seconded it. What is the object of such a proposal, and does Miss Wilson seriously think that, supposing the impossible, supposing that her wishes were carried into effect, such an arrangement would conduce to the ends for which the Midwives Act was passed? Does she seriously think that the women trained by many of the teachers and in many of the institutions recognised by the Central Midwives Board are suitable persons to replace the medical practitioner in the care of parturient women in an institution. At the time of the passage of the Act it was indignantly denied by its supporters that it was brought forward with the object of creating an order of women to replace the medical practitioner; why, then, Miss Wilson's resolution? The "unfortunate" Central Midwives Board appears determined to pile the Ossa of stupidity on the Pelion of ignorance, but in this case it graciously gave permission to Miss Wilson to withdraw her resolution!

"Gouttes de Lait."

It is now some years since the philanthropic public in France established a large number of dépôts, under the names of *gouttes de lait*, where suitable artificial food might be distributed to infants and instruction given to nursing mothers as to the care of their young. The institutions became so popular that they have increased greatly in number, and have spread not only to the various cities of France, but to Brussels and other Belgian cities. From the start the movement received a good share of criticism from the medical profession, and with the growth of popularity among the people, the criticism has become more pronounced. As long as the main object of the "*gouttes de lait*" was the instruction of the mothers, there could be no opinion adverse to their utility, but, as the very name implies, their principal work is the distribution of artificial food. In a recent number of the *Journal Medical de Bruxelles* there is a strong criticism of the whole system by Dr. Marique. He cites as an example of the work done at the dépôt the fact that at one, of the mothers who attended only 2½ per cent. were suckling their children. He further points out that the establishment of these institutions has diverted funds from much more important and useful charities. Moreover, better results would be obtained if, instead of giving milk to the babies, money were spent in enabling the mothers to stay from work sufficiently long to suckle the children themselves. An instance is quoted of the result of the action of an employer of labour in Dornach in Alsace many years ago. This gentleman insisted on female employes remaining from work for at least six weeks after confinement, and he

continued to pay them as if they were working ; infant mortality fell from 40 to 25 per cent. The defence of the "*gouttes de lait*," as given in the same journal by Dr. Lernst, appears to be that the mothers will not suckle their children at any rate, and that therefore it is better that the infants should be provided with suitable artificial food. There is doubtless some scope for institutions of the sort, but there is the greatest need for care in their management. Anything which encourages mothers to substitute artificial for natural feeding is a danger to the vitality of the race.

Oysters and Sewage.

AN interesting series of experiments has just been carried out by Dr. Klein, at the instance of the Fishmongers' Company, with a view to ascertaining the condition and appearance of shell-fish contaminated with intestinal organisms. Oysters, cockles, and mussels were used, and their behaviour examined both when directly infected artificially with *Bacillus typhosus*, and also when kept for twenty-four hours in infected sea-water. Dr. Klein was able to show that in the case of oysters the bacilli were readily taken up into the organs of the molluscs under both sets of conditions, but that if the oysters were clean at starting they rapidly rid themselves of the micro-organisms when placed in fresh sea-water that was frequently changed. On the other hand, the clearing process was found to be much slower if the oysters were kept for any length of time in a dry state before being put into clean water. All the oysters taken from polluted sources were much more difficult to cleanse than those that were clean at the outset, and this process was again further prolonged if they were kept away from sea-water before the cleansing process was finished. Mussels took up the bacilli rapidly, and rid themselves of them fairly quickly when placed in sea-water ; but cockles, though they eagerly absorbed the organisms, took a long time to disembarass themselves of them. It must be remembered, however, that interesting as these experiments are, all experiments are open to fallacies, especially when all the accompanying conditions cannot be reproduced, and it will not do for merchants to fatten their oysters in polluted waters, and then place them for a few days in sea-water to clean themselves. There can be no positive safety in any process short of keeping oysters and other shell-fish in absolutely irreproachable water throughout their whole existence.

The Orthopædic Hospital of Ireland.

AN interesting function took place last week in Dublin, when the new premises of the Orthopædic Hospital were opened by the Lord Lieutenant and Countess Dudley. It is only something over twenty years since the Orthopædic Hospital was first started in very modest premises on the quays near Messrs. Guinness and Co.'s brewery. After some years in these quarters a move was made to the more central situation of Great Brunswick

Street, and now still larger premises having been required, the hospital has been again moved to Upper Merrion Street. It has there acquired an excellent and commodious house, which should afford every convenience for the carrying on of its work. During the whole course of its life, one of its founders, Mr. R. L. Swan, has been upon the staff of the hospital, and it is a matter for congratulation to him and his colleagues that the institution in whose small beginnings he took part a quarter of a century ago has now become housed in premises more suitable for modern surgical requirements.

The Prospect of Drought.

SOME justifiable anxiety is being felt at the present moment in many parts of the country as to the water prospects of the year. Last year was a dry one in England, only 20 inches as opposed to 24 inches of rain on the Continent having fallen, and much of this was evaporated quickly by the heat of the sun. So far this year things have been quite as bad, the rainfall in London being only about half the normal. If this state of things continues a serious situation may be created, for if there be not plenty of rain before the end of March we shall have to wait some five or six months before any considerable quantity can soak into the ground to supply wells and streams. Many local authorities in the North and in the Midlands are feeling disturbed at the prospect before them, and in Bath already the question of limiting the water supply is under discussion. London, Manchester, and the big towns which have practically unlimited resources to draw upon will probably not be affected perceptibly, but places that depend on spring and well water will be placed in an invidious position. It is hardly necessary to point out the grave menace to health that any curtailment of the water supply over large areas of the country is likely to entail, for water is intimately related to every aspect of personal and public hygiene. Moreover, dry years are invariably unhealthy years, in which diarrhoea and typhoid are rife, and apt to exact a high complement of victims. Although it may be better for umbrella-makers than for milliners, we must all hope for rain unless we wish the undertaker to have an exceptionally prosperous season.

The Effect of Anti-Vaccination.

If anti-vaccinationists were people who could learn from experience, then the present condition of the Union of Dewsbury would be an object-lesson of value to the country. As it is, it is merely a disgrace to our civilisation. Dewsbury has always been notorious for its anti-vaccinationist prejudices, and like Leicester and Gloucester, of similar repute, it has now suffered for them. Moreover, the Dewsbury Guardians not only declined to take the necessary steps to prevent an invasion by small-pox, but even when small-pox was present, they refused to attempt to

limit its spread either by the vaccination of the unaffected or the isolation of the stricken. The Local Government Board Report by Dr. Wheaton, recently issued, discloses an appalling condition of affairs. The Dewsbury Union contains, in addition to the borough of Dewsbury, the six urban districts of Thornhill, Ravensthorpe, Liversedge, Soot Hill Upper, Soot Hill Lower, and Ossett. In none of these, except in Dewsbury itself, was there at the beginning of last year any hospital provision for small-pox. Of the Dewsbury Hospital, Dr. Wheaton reports that it had not been put in proper repair, its windows were broken, heaps of refuse lay around it, and the wards were overcrowded, dirty, and ill-smelling. There was, moreover, undue incidence of the disease within a quarter of a mile of the hospital. Even up to last September, when about 600 cases of small-pox had occurred during the year, no provision for vaccination had been made. In Ravensthorpe, there being no hospital accommodation, small-pox patients were treated in their own homes. Nurses were not provided, and in some homes those who were convalescent had to nurse those who were still sick. In one house a convalescent girl of fourteen had the care of three younger children still in the acute stage. In the same house there was one unvaccinated child, and the father even then declined to permit vaccination. Even the men employed by the Urban Council to watch the infected houses and maintain isolation were not vaccinated, and many of them sickened. During the year 1904 there were in all 1,302 cases of small-pox in the Union of Dewsbury. Yet no one has been hanged.

Training of Nurses.

A MEETING was held on Wednesday last, at 20 Hanover Square, to protest against the Board of Trade licence being granted to the Incorporated Society for Promoting the Higher Education and Training of Nurses. The gathering was convened by the Matron's Council and the Society for the State Registration of Nurses, and was presided over by Lady Helen Munro Fergusson. A good many of the leaders of the nursing profession were present, and the speeches made were emphatic in condemnation of the proposed body as exponents of nursing and hospital opinion. It was pointed out that of the signatories to the memorandum of the projected association only Mr. Cosmo Bonsor had any knowledge of hospital administration, whilst of nursing questions in particular no single one had any special experience. The attempt to gain by a side wind an advantage that had been denied those who sailed ahead met with universal disapprobation, and on votes being taken on the resolution condemning the proposal, there were found to be no dissentients. In the face of this decision the Board of Trade are likely to be chary in consenting to the licence, and rightly so. We dealt with the subject ourselves in a recent issue, and we pointed out at that time the absurdity of the plan as put forward,

for it was proposed to fill the seats of the Council that was to control the education and examinations of nurses with nurses, leaving only two representatives of the medical profession. The Society for the State Registration of Nurses must, however, be very obtuse to the signs of the times if they imagine after their experiences of last session that a Bill embodying their proposal is likely to receive Parliamentary sanction in the near future. The same may be said of any plan that seeks to render nurses independent of medical men, and give them a colourable sanction to practise their profession as other than a subordinate one.

Pneumonia in America.

It is a striking feature of the death returns of the large American cities that pneumonia should hold so prominent a position, and the fact that it does so is giving much uneasiness to the rulers of the States. In Philadelphia pneumonia heads the list of deaths from all causes, and last year accounted for 3,360 deaths out of a total of 25,972. This contrasts markedly with the tuberculosis deaths, which numbered 3,107, and with 2,289 from the next highest cause—heart disease. In New York the prevalence of pneumonia amounts almost to the dignity of an epidemic, and the hospital resources are being somewhat severely taxed to deal with patients. In the meantime the Pneumonia Commission of the Board of Health is endeavouring to trace the origin of this unhappy state of things, and it hopes by next summer to have completed the programme of investigations that it has laid out for itself. The Commission has twenty men at work in different cities and laboratories, all pursuing independent lines of research from the clinical, preventive, and pathological points of view. The bulk of the pathological work is being carried out in the Bellevue Hospital Laboratory, a new building lately fitted up at considerable expense, and placed under the charge of Dr. Norris, who for many years assisted Dr. Prudden, pathologist to the Colleges of Physicians and Surgeons. It is greatly to be hoped that the clue to the alarming increase in pneumonia may be forthcoming, for it is not unnatural that the authorities should view with concern the rise in the pneumonia deaths from 7 per cent. to 17 per cent. in the course of twenty years. At the present moment, as we have said, pneumonia produces an even greater fatality among the population than does tuberculosis.

Medical Advice in Lay Papers.

THE question as to how far it is good taste and how far it is ethically correct for medical men to write on technical subjects in lay papers is one that is constantly cropping up, and we have our attention frequently called to border-line articles, and even to some that are over the border. It is, however, generally conceded that it is not permissible for medical men to advise and prescribe for patients in the columns of the ordinary press.

and we think that the General Medical Council would take a severe view of the case of writers who regularly contribute answers to correspondents on medical subjects, were the anonymity under which they usually shelter themselves unveiled. What, then, are we to think of a medical man who, under his own name and with his qualification appended, advises correspondents under the thinly-disguised plea of "Diet and Training"? In the March number of *C. B. Fry's Magazine* that lies before us—a healthy-toned publication, and one devoted to sports and physical culture—we find an article by a medical man whose name is associated with a certain class of popular literature, dealing with various matters under the heading mentioned above. The writer is gaining a certain *clientele* of correspondents, and to these he offers advice on subjects connected with the maintenance of "condition" from the medical point of view. In the particular number in question—whatever may be thought of the rest—there are two answers to correspondents which we think deserve careful attention. The first advises a gentleman who suffers from constipation to use Lucca oil with his daily diet, to massage the abdomen with castor oil, and if an aperient is needed not to take salines except in hot weather. The other is in reply to "Reader," who suffers from a sprained *tendo achilles* (*sic*), and this gentleman is asked if he has tried a Martin's rubber bandage. We submit to our readers the question as to how far such blind prescribing is in accordance with the traditions of the profession?

"Pathological Delirium."

It is a well-known axiom of British law that a plea of drunkenness is no excuse for crime committed by a person in a state of intoxication. Many a time the attempt has been made to override that position. Not long ago an Irish judge in a notorious case accepted a plea of the kind in question in extenuation of a most serious crime. The ingenuity of the lawyers in our own country, however, has never yet attained so sublime a height as that reached in a recent trial at Bundenburg. A large landowner of the district was accused of attempting to murder his steward by firing at him with a revolver in the course of a quarrel. Defendant's counsel pleaded that the prisoner was not responsible for his act, as he had been drinking, and several authorities on psychiatry declared him to be suffering from "pathological delirium," in consequence of free indulgence in intoxicants. The prisoner was thereupon promptly acquitted, and German law became enriched by a precedent that, without casting any great slur upon the national character, is likely to become extremely popular in the beer-drinking Fatherland. Were a drunken man held to be not criminally responsible in the United Kingdom, a large proportion of crime would go unpunished, including murder and many of the most serious offences against the person. It

would be a sorry day for society were the doctrine of "pathological delirium" to become established in British law. It appears to be really a hybrid kind of permissive class legislation, to be used on special occasions.

Myoidema.

A PECULIAR form of muscular contraction occurring in connection with diseases of the chest was first described by Dr. William Stokes, of Dublin, in 1830. Sixteen years later, Dowler, of New York, observed the same phenomenon in the cadaver. The term "myotatic irritability" was applied by Lawson Tait, in 1876, to the contraction of muscle fibres when percussed. Small, transient, local swellings, with a well-defined border, and elevated above the surrounding skin, may appear sometimes, the condition being then spoken of as "myoidema." Dr. H. L. Shively, (a) of New York, has summarised the literature upon the subject, and it may be at once noted that this curious muscular phenomenon does not only occur in phthisis, but in several wasting diseases. The pectoralis major is the muscle most usually affected, while the sign is hardly ever seen in the lower extremities. An attempt was made by Rudolph Schmidt to explain the occurrence of myoidema in pulmonary tuberculosis on the grounds of the anatomical relationship of the apex of the lung to the nerves of the brachial plexus. Its value as a clinical sign of early phthisis has many times been discussed, and very opposite views regarding it have been expressed. Dr. Samuel West found that myoidema was present in 3 out of 275 general medical and surgical cases. Dr. Shively has examined 750 consecutive cases of tuberculosis of the lungs with a view to ascertaining whether any form of myotatic irritability was at all frequent. The sign was present in 703 instances. Of 196 cases of incipient phthisis, myoidema was only absent in 18. It is not always constant, however, even in the same patient. When properly sought for, myoidema can never be overlooked, and although it cannot be absolutely regarded as having any real pathognomonic value, yet its occurrence in conjunction with other symptoms may be of some assistance in the diagnosis of early phthisis.

Governesses' Insanity.

THE altered system of modern education, the earlier age at which most children are packed off to school, combined with the growing refusal on the part of parents to employ uncertificated instructresses, are responsible for the increasing difficulty experienced by the individual who seeks to make a living by private teaching. A glance at the advertisement columns of the daily papers is sufficient to show that 50 per cent. more is required of governesses nowadays than was the case twenty years ago. They are expected to be thoroughly conversant with at least two modern languages, to be accomplished pianists and voice

(a) *New York Medical Journal*, January 14th, 1905.

trainers, to understand elementary science—physiology, most probably, excepted—to be well up in the classics, and to excel with the pencil and brush. In addition to these items, they must also be willing to supervise home-work, including pianoforte practice, and to throw themselves heart and soul into the various games and recreations of their young charges. A highly-educated woman may, perhaps, fulfil all or chief of these modest requirements, but unless she happens to possess a diploma of some sort she will have little chance in securing a good berth. This straining after certificates which is often undertaken when the proper work of the day is over, together with the worry experienced by the insecurity of their position, are among the chief predisposing causes of mental unsoundness as met with in these individuals as a class. So large, indeed, is the percentage of female private teachers amongst the patients of asylums that Dr. Savage has recently classified the disease as "governesses' insanity." Many of these hapless ladies have had to resort to teaching as a result of sudden ill-fortune, perhaps at an age when they can no longer adapt themselves quickly to new surroundings. The old-fashioned style of teaching may have some advantages, but it is not suited to the needs of the present day.

Surgeon-General Evatt and the Royal Colleges of Physicians and Surgeons of Ireland.

SIR THOMAS MYLES, in delivering a presidential address before the annual meeting of the Leinster branch of the British Medical Association made a full and explicit reply to the extraordinary charges brought by Surgeon-General Evatt against the Irish Colleges. Sir Thomas Myles referred to the ignorance displayed of the functions of the Colleges as nothing short of colossal; he described the limitations that hedged in their actions and dwelt on the many occasions on which the Colleges had striven to assist the officers of the Poor-law Medical Service, and to push forward the work of reform. Sir Thomas considered that the most extraordinary part of an extraordinary document was the reference to the position of the Irish Medical Association, and the manner in which it was to terrorise the Colleges. We are glad to notice that the Editor of the *Journal* of the Irish Medical Association stated that Surgeon-General Evatt's report had not been adopted by the Association, and that so far as he knew it would never be adopted, as a resolution had been passed by the Committee of Council recommending the Council to reject it altogether. This is a wise course to adopt, so far as that part of the report which deals with the Royal Colleges is concerned; but we should like, in the interests of the Irish Medical Association, that Surgeon-General Evatt's criticisms on the present management of the affairs of the Irish Medical Association should see daylight. We know that in this direction a radical reform is necessary, and it would be of value to

know what the General recommends, even if his recommendations in this case also are fatuous.

PERSONAL.

THE new Orthopædic Hospital of Ireland was opened by His Excellency Earl Dudley, when a very large company assembled to receive him and the Countess of Dudley. The hospital has now been established in Upper Merrion Street, a fine house having been secured and admirably fitted up for the special work.

A PAVILION for light and electric treatment has been opened at the Cardiff Infirmary. Through the generosity of Mrs. W. H. Martin, the building comprises an X-ray room, high-frequency sinusoidal room, Finsen lamp room, photographic and dark rooms, and a dressing and waiting room.

MR. PAUL WATERHOUSE has been unanimously appointed by Sir Donald Currie's Donation Committee architect to carry out the erection of the School of Advanced Medical Studies, students' house, and the nurses' home in connection with University College Hospital.

DR. W. A. MACKAY and Dr. Ian Macdonald, two Scottish practitioners in Huelva, Andalusia, Spain, have been elected honorary members of the Academy of Medicine and Surgery of Seville.

DR. WILLIAM OSLER, in bidding farewell to Johns Hopkins University, where he resigns the professorship of medicine on leaving for Oxford, advocated frequent changes of professors for their own good and that of their universities.

THE Transvaal Medical Council has elected Dr. W. F. Davies, of Johannesburg, as its first president. Dr. Davies is the son of Dr. Ebenezer Davies, Swansea, medical officer of health for Swansea.

THE council of University College, London, have appointed Dr. A. R. Cushny, of the University of Michigan, United States of America, to the Chair of Pharmacology and Materia Medica.

ON receiving from Professor F. T. Roberts his resignation of the Holme Professorship of Clinical Medicine and his physicianship at University College Hospital, the council adopted the following resolution: "That the council, in accepting with much regret the resignation of Professor F. T. Roberts of his offices of Holme Professor of Medicine and Clinical Medicine and physician to the hospital, desire to place on record their high appreciation of the services he has rendered to the college and hospital during his long connection with them, and of the distinction he has conferred upon the chair he has held."

PRINCE FRANCIS OF TECK presided on the 23rd inst at the annual Court of Governors of Middlesex Hospital, which was held in the board-room at the hospital.

DR. B. BARNETT, Assistant Medical Officer of Health, Hong Kong, is leaving that Colony to take up duty as Assistant Inspector of Hospitals in Egypt. Dr. Barnett, before proceeding to Hong Kong, in 1903, was Assistant Medical Registrar of St. George's Hospital, London.

THE President of the Royal College of Physicians of Ireland, Dr. W. J. Smyly, will entertain the Fellows of the College at a banquet in the College Hall on Saturday next, March 4th. The Lord Lieutenant has signified his intention of honouring the dinner by his presence.

AMONG those on whom the Senatus of the University of St. Andrews has resolved to confer the honorary

degree of LL.D. at the graduation ceremony this month, is Dr. Geo. A. Gibson, Edinburgh, author of "Diseases of the Heart and Aorta," and other well-known books.

THE managers of the Edinburgh Royal Infirmary have filled up the medical registrarship rendered vacant by the untimely death of Dr. Lockhart Gillespie, who had occupied the position for twelve years, by appointing Dr. A. Dingwall Fordyce, F.R.C.P.Ed., from among four applicants for the post.

ALEXANDER CRUM BROWN, M.D.Edin., D.Sc.Lond., F.R.S., Professor of Chemistry in the University of Edinburgh, a position which he has held since 1869; and Sir William Whittla, M.D., R.U.I., L.R.C.P., and S. Edin., Professor of Materia Medica and Therapeutics, Queen's College, Belfast, are among those upon whom the Senate of Glasgow University at its meeting on February 16th, resolved to confer the honorary degree of Doctor of Laws (LL.D.).

DR. DONALD MACKINTOSH will read a paper on "The Control of Hospital Expenditure with Efficiency" before the Hospitals Association at Charing Cross Hospital on Friday, March 3rd, at 8 o'clock. Tickets from the Hon. Secretary, the Hospital Building, 28, Southampton Street, Strand, W.C.

THE Gold Medal, founded by the late Sir Gilbert Blane, Bart., to be given biennially has been awarded by the Medical Director General of the Navy, and the Presidents of the Royal College of Physicians and the Royal College of Surgeons, to Surgeon S. T. Reid, R.N., for his "Journal" of H.M.S. *Vestal*, 1901-2, and to Surgeon R. W. G. Stewart, M.B., R.N., for his "Journals" of H.M. Ships *Latona* and *Thames*, 1903.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

EDINBURGH.

ANNUAL DINNER OF THE ROYAL MEDICAL SOCIETY.—Professor Ronald Ross, C.B., F.R.S., was the guest of the evening at the President's Annual Dinner, which was held in the Hall of the Society on February 14th. About eighty were present, the guests including the Lord Provost, the Lord Justice Clerk, the Bishop of Edinburgh, the Presidents of the two Royal Colleges, and several members of the Senatus Academicus. A most successful and enjoyable evening was passed, Dr. Fletcher, Senior President, who was in the chair, proposing Professor Ross's health in felicitous terms, while the latter after replying, gave the toast of "The Royal Medical Society," to which Dr. Campbell Geddes responded. "The Sister Professions" was given by Dr. G. A. Gilson, and replied to by the Bishop of Edinburgh, and the Lord Justice Clerk.

PHYSICAL CONDITION OF SCHOOL CHILDREN IN DUNDEE.—Under the auspices of the Dundee Social Union an investigation was made during last summer of the physical condition of a section of the people. The inquiry was conducted in four board schools, one voluntary school, and one private academy; over 1,000 children were examined in these institutions. The following are a few of the facts elicited in the inquiry:—In elementary and board schools the physique of the children is defective, as regards both weight and height, when compared with Sir Francis Galton's averages, and with the average for the Harris Academy, Dundee. For example, the average weight of a boy of thirteen is 9 lb. below Galton's average, and that of an elementary school girl of twelve is 9 lb. below the average of the Harris Academy for the same age. The lengths and weight of 498 babies born in the Maternity Hospital, belonging to the same class as the poorer children in elementary schools, give an average weight less than, and an average height greater than Sir Francis Galton's figures. Dr. Templeman, Medical

Officer of Health, in his introductory medical report calls attention to the deficient weight of the poorer children, and states that their dietary does not include sufficient of the special elements necessary for growth, much of the parents' earnings being wasted on foods of low nutritive value, but which to them have the great advantage of requiring little or no preparation. A remarkable state of affairs was found in connection with the vision of the children, no less than one third of those examined suffering from defects so great as to interfere with their power of receiving instruction by ordinary school methods. Assuming the same proportion to prevail throughout the Dundee schools it means that nearly 7,000 children are seriously handicapped in the educational race, and at least 600 are in the position of running the risk of serious structural changes in the eyes. As a whole the nutrition of the boys was bad; the only bone disease found was rickets; the teeth show great evidences of neglect. Dr. Emily Thompson, reporting on the physique of the girls, notes that the condition of the heart was in many cases, specially from eleven to thirteen years, unsatisfactory, with signs of weakness and flabbiness from underfeeding and over-exertion. The whole report is well worthy of perusal.

SMALL-POX has again re-appeared in the neighbourhood of Edinburgh, four cases having been intimated during the past ten days in Leith. As the Burgh of Leith was very thoroughly re-vaccinated last year, thanks to the enterprise of the Town Council in offering free vaccination and a bonus of half-a-crown to all who submitted to the operation, it is unlikely that the disease will spread to any extent.

GLASGOW.

THE PROGRESS OF SURGERY.—At the meeting of the Glasgow Southern Medical Society, held on Thursday last, 24th ult., Prof. H. E. Clark, after expressing his great appreciation of the high honour conferred upon him by his election to the office of President of the Society, delivered an address on the progress of surgery, during the last thirty-four years, representing as they do the years of his professional life. He referred to the rapid tendency there had been to specialism in surgery and the growth of confidence in surgical methods. In the year 1870 the number of operations performed in the Royal Infirmary, the only general hospital then existing in the city, were 470, whereas in the year 1903, over 6,300 operations were performed in the Royal Western, and Victoria Infirmaries, exclusive of the operations performed in such special hospitals as the Samaritan and others. The rate of mortality in the Royal Infirmary in 1870 was 5·8, in the year 1903 it was 8·7; this considerable increase was to be explained on the ground that there were now a much larger number of serious surgical cases in the wards of general hospitals, compared with what there were in 1870. In the Royal Infirmary the rate of mortality was slightly below what it was in the Western or Victoria Infirmaries. Mr. Clark proceeded to sketch briefly and succinctly the operations now performed on the various organs of the body, brain, kidney, liver, stomach, peritoneum, etc. The presence of albuminuria is no longer, he held, an objection to the performance of any operation. The rapid advances in bacteriology were next passed in rapid review, and the valuable assistance rendered by the bacteriologist to the surgeon was readily acknowledged. In the Royal Infirmary the bedding was constantly being tested in the laboratory and when it was found septic was, in some very bad cases, destroyed, and in others subjected to disinfection by boiling, etc., before being again used. In this way many troublesome forms of dermatitis were now avoided which were at one time prevalent. A case was mentioned where a man entered the hospital with a badly swollen lip. The house-surgeon, discovered on examination the anthrax bacillus, and at once sent for Mr. Clark, who immediately operated, and so saved the man's life. In the experience of Mr. Clark the treatment by means of anti-toxins had been disappointing. The Rontgen Rays had proved most valuable in-surgical.

work, and their possibilities in the future, both in surgical and medical cases, it was quite impossible to estimate at present. A highly interesting and instructive address was brought to a close by the demonstration of several peculiarly interesting cases, including that of a young man, who was shown, and from whom the left arm including the scapula, and a portion of the clavicle were removed for a sarcomatous growth. Another case was that of a railway porter who got stabbed in the thigh, and where on account of profuse hæmorrhage the profunda femoris artery had to be ligatured; the hæmorrhage recurring, the femoral wasted and again it became necessary to ligature the common iliac artery through the lumbar muscles by means of an incision from below the ribs and along the crest of the ilium. The man made an excellent recovery. The ex-President of the Society, Dr. James Hamilton, in moving a hearty vote of thanks to Professor Clark for his admirable address, expressed the hope that it would be printed.

BELFAST.

The New High Sheriff.—Dr. Henry O'Neill, B.L., J.P., was last week sworn in as High Sheriff of the city of Belfast, and celebrated the occasion in a manner worthy of imitation by giving donations as follows:—To the Royal Victoria Hospital, £50; to the Mater Infirmorum Hospital, £10; to the Forster Green Hospital for Consumption and Diseases of the Chest, £5; to the Home for the Blind, £5; to the Maternity Hospital, £5; to the Day Nurseries, £5; to the Society for Providing Nurses for the Sick Poor, £5; to the Samaritan Hospital, £5; to the Presbyterian Orphan Society, £5; to the Protestant Orphan Society, £5; and to the Domestic Mission to the Poor, £5.

Prospective Legacy to the Forster Green Hospital.—It is said that the late Mr. R. W. Murray, of Belfast, has left a sum of over £120,000, the life interest of which goes to his widow, and at her decease the sum will be divided equally between the Forster Green Hospital for Consumption and the London Missionary Society.

Belfast Maternity Hospital.—The one hundred and eleventh annual meeting of this hospital was held last week, and was the first in the new building, which was opened in November. In spite of the interruption caused in the work by the removal from the old hospital to the new, 297 patients were admitted during the year, and 291 attended in their own homes. A serious outbreak of German measles occurred in the spring, and proved fatal to two patients. There was one fatal case of acute mania, and five other deaths were all in-patients moribund on admission. Ten nurses were trained, and received their diplomas.

Belfast Samaritan Hospital.—The annual meeting of this institution was held last week, but the medical report presented at it does not give many details of the work, as is natural. The patients treated in the extern department numbered 435, and in the intern department 134, of whom 118 required surgical operations. There were seven deaths.

Small-pox has reappeared in Belfast, some three or four cases having been notified during the past week.

Correspondence.

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

THE LINCOLN EPIDEMIC.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.
SIR,—My attention has been drawn to the leading article in your issue of the 22nd inst., on the epidemic at Lincoln, and the means to employ to assure a supply of uncontaminated water to the citizens. You mention the "Salvator" (Vaillard-Dennarde's system) sterilising apparatus. Now, I happen to be much interested in the operation of that most useful appliance and have seen it at work in France, where it renders important service in many towns and institutions where the water supply—as so frequently happens in

Continental towns—is drawn from polluted sources. It is the only method I know of that will instantly produce indefinite quantities of cool potable water, sterilized in the only manner that will render dangerous water innocuous, by the use of great heat for a definite period. I am astonished the Lincolnians do not set up half a dozen of the machines in their town in places readily accessible, so that all those families who choose to use the water for drinking and cooking might ensure immunity from the scourge. From personal experience I can testify that the apparatus has been found to answer all requirements where it has been used in France. From a practical point of view Lincoln could have the apparatus brought over and set up within a week. In other words, within ten days the citizens of Lincoln could be drinking clean water. There is no other way yet devised by the wit of man in which that desirable end could be accomplished.

I am, Sir, yours truly,

VIATOR.

Hastings, February 26th, 1905.

OXONIENSIS!

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Oxford may be wise in having chosen as its Professor of Medicine a man who holds the view expressed by Dr. Osler, that after the age of forty men are worth little or nothing.

It looks rather as if Dr. Osler's views were correct if we may judge by the Oxford School of Medicine, and perhaps the University has chosen well. It is only to be hoped that Dr. Osler does not take the view that his life is finished, and that as he can be of no use in America he had better come over to Oxford and retire from active life. Oxford won't gain much if he does.

I am, sir, yours truly,

R. L.

STATE REGISTRATION OF NURSES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Referring to an article in your issue of Feb. 15th, I beg to point out that you have fallen into a grave error in assuming that the application to the Board of Trade, to incorporate a Society for promoting the Higher Education and Training of Nurses, has been made by the promoters of the Bill for the State Registration of Trained Nurses. On the contrary, the subscribers to the petition to the Board of Trade are seven well-known philanthropic financiers of the City of London, and the general body of nurses, as well as the members of the Society for State Registration have not been consulted and strongly oppose such a measure.

I am, Sir, yours truly,

AN ADVOCATE FOR STATE REGISTRATION.

February 20th, 1905.

[We are aware that the Society for the State Registration of Nurses is opposed to the issue of the proposed licence, as "An Advocate of State Registration" will see in reading our editorial columns this week. There are, however, other parties interested in the question besides the official society, and it was to these we referred. While no one can object to the higher education of nurses in the abstract, our own opinion on the constitution of the projected body was strongly expressed in the article our correspondent mentions.—Ed.]

Obituary.

S. THOMSON, M.D., D.Sc., OF GLASGOW.

THE profession in Glasgow has sustained a serious loss, and the citizens have lost an accomplished physician, through the too premature death of Dr. Thomson. He was only forty-eight years of age. He had been laid aside from active professional work for five or six months from granular kidney disease. Some improvement in his condition followed the first two or three months' rest, when the hope was cherished that he might be

spared to resume his professional work as family physician, consultant and teacher, but it was decreed otherwise. A *post mortem* examination revealed an aneurism of the aorta. Dr. Thomson graduated B. Sc. in 1880 and M.B. in 1882. In 1897 he graduated M.D. with honours and Bellahoustan Gold Medal, and D.Sc. in 1901. As assistant to Dr. James Finlayson he was closely identified with the teaching of clinical medicine in the wards of the Western Infirmary. In the year 1899 he was appointed to the Chair of Medicine in Anderson's College. He was generally recognised as a most successful teacher, his success being largely due to his painstaking methods in imparting to the large number of students in his classes the true essentials of medicine. For many years he gave much of his time to the teaching of the nurses in the Western Infirmary, by all of whom he was held in the highest regard and esteem. Always a close student of medicine himself, he was always in complete sympathy with his students in their desire to acquire a knowledge of their profession. By students, the whole of the medical profession in the city, and the citizens generally his loss is deeply mourned, as well as by a sorrowing widow.

J. HAMLLEN-WILLIAMS, M.R.C.S., L.R.C.P.LON., J.P.

WE regret to record the death of Dr. Hamlen-Williams, J.P., who for many years resided at Pontypridd, where he took a prominent position as a district councillor and holder of other public posts. He had had a successful career at the Middlesex Hospital, but he did not practise, preferring the enjoyments of a country life. The deceased's original name was Theophilus Richard Hamlen, but after the death of his uncle he assumed the name of Hamlen-Williams.

LT.-COL. E. DENHAM TOMLINSON, A.M.D.

WE note at Folkestone, in his sixty-ninth year, the death of Lieutenant-Colonel Edward Denham Tomlinson, A.M.D. (retired), and late of the York and Lancaster Regiment. He entered the army in 1860 as assistant surgeon, served in the New Zealand war, and was present at the capture of the redoubt of Katikara, and of the Pahs at Manutahi, and the destruction of Pahs and villages in the neighbourhood of Warea. He retired in 1880.

HORACE VAVASOUR SANDFORD, L.R.C.P.LOND.

MR. H. V. SANDFORD who died on February 5th, at the age of seventy-eight years, was one of the first medical officers of health to be appointed to a combined sanitary district, having been elected medical officer of health of the City of Hereford in 1874. In 1899, owing to failing health he resigned all his appointments. His reports were of the utmost value in the young days of public health work and were printed from the first. His death removes one of the pioneers of public health science.

SAMUEL HOLLINGSWORTH AGAR,
L.R.C.P.IREL., L.R.C.S.IREL.

THE death of Mr. Samuel Hollingsworth Agar, at Henley-in-Arden, Birmingham, on Feb. 11th, has removed a useful member of the profession in which he was well-known and much respected. Mr. Agar was in his seventy-fourth year. He was a native of county Wicklow and after taking his L.R.C.S.I., went to Henley-in-Arden in 1854. After a time, giving up general practice, he devoted his attention to the care of the insane, and became proprietor of a large private asylum—Glendossill, Henley-in-Arden—and his conduct of this establishment and his care and attention to the patients obtained him a wide reputation. Mr. Agar was a man of much public spirit and a member of the Warwickshire county council and a justice of the peace for the county. Mr. Agar leaves two sons, one of whom is a member of the medical profession.

ALEXANDER CRAWFORD, M.B., C.M.GLAS.

WE much regret to announce the death of Dr. Crawford, of Burdett Road, Stepney, London. At the outbreak of typhus fever in the East End he was called to attend one of the sufferers from that complaint. Soon afterwards he was attacked with illness, supposed to be influenza, and was admitted to the London Hospital, where he shortly afterwards died. As the cause of death was in doubt an inquest was held, but the *post-mortem* examination revealed no further facts. The Medical Officer of Health for Stepney, Dr. D. L. Thomas, inclines strongly to the opinion that the cause of death was typhus fever. In any case the sympathy of medical men will be with a professional brother, who has fallen in the front of the battle.

ON Wednesday, March 15th, at 7.30 p.m., the anniversary dinner of the Medical Society of London will be held at the Whitehall Rooms of the Hotel Métropole. Communications with regard to the dinner should be addressed to the honorary secretaries at 11 Chandos Street, W.

A SOCIETY for the study of questions of social medicine and hygiene and medical statistics was formally constituted in Berlin on February 16th, at a meeting of a large number of medical practitioners, political economists and sociologists. Professor Mayer, of the Imperial Statistical Bureau, Dr. Dietrich, of the Russian Cultus-Ministry, and Professor Lassar were elected Presidents.

THE Court of the Worshipful Company of Fishmongers has granted a sum of £1,000 towards the funds necessary for the incorporation of University College in the University of London. By this grant the amount still required to complete the funds necessary for incorporation is reduced to £17,000, a total of £183,000 having now been raised for this purpose. The Bill for the transfer of the College to the University was approved at the annual general meeting of the College on February 22nd.

Literature.

SHAW-MACKENZIE ON HYPODERMIC MEDICATION IN THE TREATMENT OF INOPERABLE CANCER.(a)

THE chemico-biological theory of the etiology of cancer is one which all who are interested in this fell disease will do well to follow up. Indeed, it may not be long before some startling developments will be evolved in this regard, judging from the scientific hold which the theory is beginning to acquire. The whole matter simply teems with interest; it offers an entirely new field of investigation and research in the endeavour to elucidate what cancer is, and in view of the lamentable failure of the parasitic theory of the disease, one can only hope that in this new field of research tangible results will be obtained which will go far towards robbing cancer of its horrors. That there is at least a reasonable hope of the possibility of this is proved by the results recorded by the author in this pamphlet. The method of hypodermic injection in the treatment of cancer is, of course, not new. But it is undoubtedly remarkable that chian turpentine when employed in this form should have yielded the gratifying results which the author's cases show. This would seem to indicate that the late Mr. Clay of Birmingham was probably right in his estimation of the value of chian turpentine in the treatment of cancer, but wrong in the mode by which he administered the drug. In the second part of his pamphlet the author deals with the hypodermic methods of treat-

(a) "Some Methods of Hypodermic Medication in the Treatment of Inoperable Cancer." By John A. Shaw-Mackenzie, M.D. Lond. London: Baillière, Tindall and Cox. 1904. 1s. net.

ment practised by Mr. Webb, of Melbourne. The hypodermic solution upon which the latter relies is one prepared with soap, more euphemistically described as oleate of sodium. Notes of some cases are given, all of which unmistakably show that hypodermic injections of a soap solution not only remove some of the worst features of the disease, namely, pain and fœtor, but even seem to have the power of arresting its progress. Precisely how chian turpentine and the soap solution act in this connection is, of course, still a matter of conjecture. But herein is concerned the chemico-biological theory of the origin of cancer. Mr. Webb holds that the first lesion in carcinoma is "crystallisation of cholesterol from the living cell, which may be caused either by local injury or chemical change in the cholesterol, as is affected by soot or by some change in the liver secretion." Dr. Shaw-Mackenzie points out that oil of turpentine is a solvent of cholesterol, and it is claimed by Mr. Webb that the same is true of soap; thus it may be by this action that the good effects of these two preparations in cancer are brought about. We have read this pamphlet with much interest, and can therefore cordially recommend its perusal, more particularly by reason of the important issues which it opens out, as well as upon the ground that it deals with facts which should be known to the profession generally.

MACNAUGHTON-JONES ON DISEASES OF WOMEN. (a)

The ninth edition of Dr. Macnaughton-Jones's most popular and valuable work will be sure of a warm welcome not only from the students and practitioners for whom it is intended, but also from all gynaecologists. The present edition appears for the first time in Messrs. Bailliere, Tindall and Cox's well-known "University Series," to which it constitutes a valuable addition. It has been practically rewritten, and a large number of beautifully coloured and plain plates and other illustrations in the text have been added.

The general system and arrangement of the book is similar to those of former editions, and is so well-known as not to call for criticism. We are sorry, however, that the author still adheres to his former plan, and that the diseases of the vagina and vulva find their place in one of the last chapters of the book. Such an arrangement is an inversion of the usual order of things and does not appear to us to be suitable.

There is a very excellent description of atmocausis and zestocausis, but there are two plates shown which are apt to prove misleading. Both of them show "Uterus and adnexa removed by atmocausis." This is surely a printer's slip for "after atmocausis." This, however, is a minor blemish. To criticise, however, in detail a book which has reached its ninth edition and become a recognised standard authority, would, indeed, be superfluous, and we need only heartily congratulate Dr. Macnaughton-Jones and his publishers on the present edition of what we have always considered to be one of the best epitomes of gynaecology in the English language.

YEAR-BOOK OF PHARMACY. (b)

The present volume of this excellent year-book is of more than ordinary interest, both for what it omits to mention in the progress of chemical knowledge and for what it contains. The space at the disposal of

(a) "Practical Manual of Diseases of Women and Uterine Therapeutics for Students and Practitioners." By H. Macnaughton-Jones, M.D., M.Ch., F.R.C.S., formerly University Professor of Midwifery and Diseases of Women and Children in the Royal University of Ireland, and Examiner in the same subjects; ex-President of the British Gynaecological Society. Ninth Edition. "University Series." London: Bailliere, Tindall, and Cox. 1904. Pp. xxv. and 1,044. With 137 Plates and 653 Illustrations in the text. Price 21s.

(b) "Year-Book of Pharmacy, comprising Abstracts of Papers contributed to British and Foreign Medical Journals from July 1st, 1903, to June 30th, 1904; with the Transactions of the British Pharmaceutical Conference at the Forty-first Annual Meeting, held at Sheffield, August, 1904." Edited by J. Braithwaite, R. Seville Park, M.A., and Edmund White, B.Sc., F.I.C. London: J. and A. Churchill. 1904.

the editors did not admit of reference to radium, hence no mention is made of the researches of the Curies, Dewar, and others. On the other hand, an excellent summary of the investigations of Charpentier and Becquerel into the nature of Blondlot's N-rays. As might be expected, arsenic and its compounds occupy considerable attention. A very valuable contribution is the summary of the papers of the Paris Municipal Laboratory on the analytical chemistry of brandy and its substitutes. Wobbe's tests for the purity of ether should interest anaesthetists. New, or newly applied, remedies are described with considerable fulness, so that both the pharmaceutical chemist and the medical practitioner have their wants provided for. We think there is no better year-book for the physicians' desk than that of pharmacy, and we cannot imagine how anyone interested in the progress of therapeutics and therapeutic remedies could be without it.

NEW BOOKS AND NEW EDITIONS.

The following have been received since the publication of our last list:—

- FELIX ALCAN.
Les Nerfs du Cœur, Anatomie et Physiologie. Par Blie De Cyon. Pp. 252.
- Le Traitement de l'Hypertrophie sénile de la Prostate. Par Dr. A. Guepin. Pp. 141. Price 2fr. 50.
- BAILLIÈRE, TINDALL AND COX (London).
A Dictionary of New Medical Terms. By George M. Gould, A.M., M.D. Pp. 571. Price 21s. net.
- Cancer and its Treatment. By A. W. Mayo Robson, D.Sc., F.R.C.S. Eng. Pp. 69.—Price 7s. 6d. net.
- Ship Surgeon's Pocket-Book and Medical Officer's Log. By W. E. Dawson. Pp. 61. Price 2s. 6d. net.
- Lateral Curvature of the Spine and Pelvic Deviations. By Richard Barwell, F.R.C.S. (sixth edition). Illustrated. Pp. 103. Price 3s. net.
- The Diagnosis and Modern Treatment of Pulmonary Consumption. By Arthur Latham, M.A., M.D., &c., &c. Second Edition. Pp. 224. Price 5s. net.
- The Principles and Practice of Asepsis. By Arthur Styles Vallack, M.B. Pp. 95. Price 2s. 6d. net.
- JOHN BALE, SONS AND DANIELSSON, LTD. (London).
The Radical Cure of Corns and Bunions. By E. Harding Freeland, F.R.C.S. Eng. Second Edition. Pp. 34. Price 1s.
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Lectures on Diseases of the Stomach and Intestines for Practitioners and Students. By Boardman Reed, M.D., Illustrated. Pp. 1021. Price 21s. net.
The Naked-Eye Anatomy of the Human Teeth. By Thos. E. Constant. Illustrated. Pp. 194. Price 7s. 6d. net.

Medical News.

The Training of Nurses.

LADY HELEN MUNRO FERGUSON presided on the 22nd ult. at a meeting, convened by the Matrons' Council of Great Britain and Ireland and the Society for the State Registration of Trained Nurses, to "enter the strongest possible protest against the licence of the Board of Trade being granted to a society which seeks to obtain absolute authority over trained nurses." The chairman said that no voluntary association could ever accomplish for the nursing profession what could be done by State registration. At present there was no recognised standard of education for a nurse and no means of control of trained nurses. The registration of nurses by Act of Parliament was the only way by which a general standard of education could be obtained. The following resolution was carried unanimously:—"That this meeting of hospital matrons and trained nurses emphatically protests against the attempt now being made by seven gentlemen in the City of London to obtain the licence of the Board of Trade to incorporate a society which seeks for authority to organise the professional education of trained nurses, to exercise disciplinary powers, and to control their work. This meeting is strongly of opinion that no such powers can be usefully or successfully exercised except by a body composed of professional persons upon which trained nurses have direct and sufficient representation." Another resolution, carried unanimously, ran:—"That this meeting earnestly supports the Bill for the registration of trained nurses, introduced into the House of Commons by Mr. Munro Ferguson, being convinced that the only possible remedy for the present disorganised condition of nursing education in this country, and the many evils now existent in the nursing world, would be the institution of a representative nursing council, empowered by Act of Parliament to supervise nursing education and maintain common rules of discipline in the nursing profession."

Education and Training of Nurses.

A LARGELY attended meeting of the Irish Nurses' Association was held on Friday last to protest against the granting by the Board of Trade of articles of association to the proposed Incorporated Society for Promoting the Higher Education and Training of Nurses. The signatures of the applicants to the Board of Trade are those of Lord Rothschild, Lord Revelstoke, Mr. G. A. Hambro, Mr. S. Hope Morley, Mr. C. H. Goschen, Mr. Hugh C. Smith, and Mr. Cosmo O. Bonsor. It was considered that, however, eminent these gentlemen may be as financiers and philanthropists, they can hardly be considered experts on the education and training of nurses, and that the scheme stands self-condemned by its want of medical and nursing repre-

sentation among the signatories, and it is also most undesirable that a fresh scheme should be submitted to a Government Department while the whole nursing question is under Parliamentary consideration. It was resolved that a petition should be sent to the Board of Trade objecting to the incorporation of the proposed Society; that the Registrars of the Royal College of Physicians and Surgeons should be asked to bring the matter under the consideration of the Fellows with a view to lodging objections; that a letter should be sent to each of the seven signatories informing them of the nurses' view of the question; and that full information be furnished to the Irish members of Parliament. We are informed that the Royal College of Physicians will consider this important matter at their monthly meeting on Friday next.

Royal College of Surgeons in Ireland.

THE annual Charter Dinner of this college was held on Saturday last, and was a most successful function, although the unavoidable absence of the Lord Lieutenant caused some disappointment. Before dinner, the Provost of Trinity College was admitted to the Honorary Fellowship of the College by the President, Dr. Arthur Chance. The President in the course of a short speech referred to the Provost as the head of a great college, a position which he had attained by his varied learning. It was because he was the first member of their profession to hold the office of Provost that the college had asked him to share with them the honour he possessed and so fully deserved. The addition of his name to the roll of Fellows would go far to add to the reputation, the dignity and the honour of the college. The Provost responded after dinner to the toast of "Our New Honorary Fellow." Other toasts followed, and amongst the speakers were Sir Antony MacDonnell, Under-Secretary of State for Ireland.

The "Sanitas" Company.

THE annual general meeting (27th in number) of the "Sanitas" Company, Limited (disinfectant manufacturers) was held on the 22nd ult., under the presidency of the Chairman, Mr. C. T. Kingzett, F.I.C., F.C.S., who congratulated the shareholders upon the continued prosperity of the business and their prospects for the future. Although the past year had not been by any means a favourable one to their class of business, it had, nevertheless, continued to expand, and their sales were greater than in any previous year. Their manufactures included practically all kinds of disinfectants and many sanitary appliances, and "Sanitas Fluid" still easily held first place as a non-poisonous and effective disinfectant for household and sick room purposes. A final dividend of 4½ per cent., and a bonus of ½ per cent., was subsequently declared, making, with the interim dividend already paid, the usual total distribution of 7½ per cent. for the year.

Irish Medical Schools and Graduates' Association.

THE annual general meeting will be held at the Hotel Cecil, Strand, on Saturday, March 18th, at 6.30 p.m. The festival dinner will be held on the same evening, when the Association will dine at the Grand Hall of the Hotel Cecil, at 7.30 p.m., the President, Sir William Whitla, in the chair. The guests of the Association on this occasion will be Mr. Thomas Lough, M.P., and probably Signor Marconi. Application for tickets (7s. 6d. each exclusive of wine), accompanied by remittance, together with the names of guests, should be forwarded as early as possible to E. Canny Ryall, Hon. Sec., 30, Harley Street, London.

The Pharmacy Bill.

A COPY of Mr. Lough's Bill to provide for the further regulation of the sale of poisons and the compounding of medical prescriptions, and to amend the Pharmacy Acts of 1852 and 1868, has been issued. The objects of the Bill are to provide that each shop for the sale of poisons shall be under the *bona fide* personal conduct and supervision of a duly qualified person, and, among other things, that the compounding of prescriptions shall be in the hands only of persons duly qualified to sell "poisons."

Notices to Correspondents, Short Letters, &c.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive Signature or Initial*, and 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 re-forwarding 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.

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.

VIATOR.—The sale of proprietary nostrums last year reached over £2,000,000. The total revenue amounted to more than £283,000.

GYNÆCOLOGIST.—Cases of galactorrhoea in virgins are extremely rare, but in 1903 Prof. Gauthier of Paris reported such a case in a spinster of 25, who suffered twelve months from it.

DR. W. H.—In selling a practice it is not obligatory to hand over the case books, but the purchaser is entitled to a full list of patients.

R.A.M.C.—One of the handiest volumes is *The Health of Armies in the Field*, by Surgeon-Major Caldwell. It ought to give all you want. The publishers are Billiers, Tindall & Cox.

LIBRARIAN (Hastings).—A surgeon in the British Service, Winterbottom, first called attention to the negro lethargy he had noticed among the natives along the littoral of Benin in 1836.

ANNALS OF NOMENCLATURE.—"Phthisiophobia" is the name given by New Yorkers to those opposing the landing of tuberculous aliens but an enterprising American chemist advertised "Hypophosphitopathy" as his new "cure for consumption."

J. G. HODGSON.—In the hope of escaping a penalty, hypnotism is often given by a prisoner as a scientific excuse and explanation for wrong-doing, but a criminal act implies a criminal intent. Unfortunately, the press in its love of sensationalism is only too willing to lend countenance to these hypnotic theories.

R. T. (York).—There is no lack of good general practitioners in Durban and Johannesburg, but if you would go "up country" a little the chances are fair. The leading medical men generally manage a trip to London every three years in order to keep in touch with medical matters.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MARCH 1st.

OBSTETRICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Dr. Giles and Dr. H. Williamson. Short Communications: Surgeon-Captain J. C. H. Leicester: A Case of Chyluria with Pregnancy.—Dr. A. H. N. Lewers: A Case of Pregnancy in a Rudimentary Uterine Cornu. The President (Dr. W. B. Dakin): The Present Teaching of Practical Midwifery in England (Inaugural Address).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. C. E. Ryall: Clinique. (Surgical.) 5.15 p.m. Dr. L. Williams: Dyspepsia and its Treatment.

CENTRAL LONDON THROAT AND EAR HOSPITAL (Gray's Inn Road, W.C.).—5 p.m. Demonstration:—Dr. Abercrombie: Nose.

THURSDAY, MARCH 2nd.

CHILDHOOD SOCIETY AND THE BRITISH CHILD-STUDY ASSOCIATION (Parker Museum, Margaret Street, W.).—8 p.m. Lecture:—Dr. F. Warner: Mental Faculty of the Child, its Growth and Culture. (Arranged by the Childhood Society.)

NORTH-EAST LONDON CLINICAL SOCIETY (Tottenham Hospital, N.).—4 p.m. Paper: Mr. A. de Frenerville: Anæsthetic Difficulties and how to Combat Them.

BOSTON SOCIETY (20 Hanover Square, W.).—8.15 p.m. Discussion on the Necessity of Accurate Measurement in X-ray and High Frequency Work (opened by Dr. W. D. Butcher).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Mr. E. Clarke: Ocular Headache: Its Causes, Diagnosis, and Treatment.

MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST (7 Fitzroy Square, W.).—5 p.m. Lecture: Dr. T. D. Lister: Bronchial Affections of Children. I. Primary. (Post-Graduate Course.)

FRIDAY, MARCH 3rd.

SOCIETY OF ANÆSTHETISTS (20 Hanover Square, W.).—8.30 p.m. Paper:—Dr. Flux: A Fatality associated with Ethyl Chloride (opened by Dr. McCardie).

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

TUESDAY, MARCH 7th.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Dr. H. Corner: Mental Affections of Childhood and Adolescence.

Vacancies.

- City of London Hospital for Diseases of the Chest, Victoria Park, E.—Resident Medical Officer. Salary £100 per annum, with board &c. Applications to the Secretary.
- City of London Hospital for Diseases of the Chest, Victoria Park, E.—Pathologist. Salary £105 per annum. Applications to the Secretary.
- Hampstead General Hospital.—Resident Medical Officer. Salary £120 per annum, with allowance for rooms. Applications to George Watts, Secretary, Parliament Hill.
- Paddington Green Children's Hospital, London, W.—Matron. Salary £100 per annum, including washing allowance. Applications to the Secretary, Paddington Green Children's Hospital, London, W.
- Birkenhead Union.—Resident Assistant Medical Officer. Salary £120 per annum, with board, washing, and apartments. Applications to John Carter, Clerk to the Guardians, Poor-law Offices, Birkenhead.
- Navy Medical Department.—Three Dental Surgeons for Portsmouth Plymouth and Chatham. Salary £1 per diem and travelling expenses when necessary. Applications to the Director General, Medical Department of the Navy, 18 Victoria Street, S.W. (See Advt.)
- 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 Thomas Hayes, Secretary.
- Lincoln County Hospital.—Senior Male House Surgeon. Salary £100 per annum, with board, lodging, and washing. Applications to the Secretary, 2 Bank Street, Lincoln.
- Licensed Victuallers' Asylum, Asylum Road, Old Kent Road, London, S.E.—Medical Officer. Salary £200 per annum. Applications to the Board of Management under cover to Alfred L. Annett, Secretary, 28 New Bridge, Street, London, E.C.
- County Borough Asylum, near Middlesbrough, Yorkshire.—Medical Superintendent. Salary £450 per annum, with unfurnished house, rates, taxes, fire, light, washing, and garden produce. Applications to Alfred Sockett, Clerk to the Visitors, Municipal Buildings, Middlesbrough.

Appointments.

- CHAPMAN, WALTER, M.B., B.Ch. Birm., L.R.C.P. Lond., M.R.C.S.**, Public Vaccinator for the Fourth District of the Totnes, (Devon) Union.
- COOK, HERBERT, G. G., M.D. Lond., F.R.C.S. Eng., D.P.H. Camb.**, Medical Officer to H.M. Prison at Cardiff.
- DOUGLAS-CRAWFORD, DOUGLAS, M.B. Edin., F.R.C.S. Eng.**, Honorary Consulting Surgeon to the Liverpool Dental Hospital.
- EVANS, H. W., M.R.C.S. Eng., L.R.C.P. Edin.**, Certifying Surgeon under the Factory and Workshop Act for the Littleport District of the county of Cambridge.
- HAWES, G. C. B., M.B.C.S., L.R.C.P. Lond.**, Certifying Surgeon under the Factory and Workshop Act for the Pangbourne and Whitechurch District of the counties of Berks and Oxford.
- KENT, PRECY WHEELER, M.B.C.S., L.R.O.P., D.P.H. Camb.**, Surgeon to the Glamorgan County Police at Barry.

Births.

- HENRY.**—On Feb. 27th, at Wincott House, 175 Kennington Road, S.E., the wife of George Nicol Henry, M.B. C.M., of a son.
- JELLETT.**—On Feb. 27th, at 61 Lower Mount Street, Dublin, the wife of Henry Jellett, M.D., of a son.

Marriages.

- BOWLE-CUFFE-ADAMS.**—On Feb. 24th, at St. Mary's Church, Isleworth, Clement Bowle, R.A.M.C., second son of Edward Bowle, Esq., of Salisbury, to Marjorie, daughter of Mrs. Charles Cuffe-Adams, and the late Charles Cuffe Adams, Esq., of Ealing.
- HENMANS-TINLEY.**—On Feb. 15th, at All Saints' Church, Holbeach, Lawrence Fielder Henmans, M.B., of 9 Lewisham Park, S.E., to Harriet Annie, elder daughter of the late Joseph Tinley, of Holbeach.
- SHELDON-CAITHNESS.**—On Feb. 25th, at St. Peter's, Ealing, Walter Sirt, M.B.C.S., L.R.C.P., eldest son of Thomas Sheldon, M.D., J.P., of Powis Square, W., to Ethel, second daughter of the late James Ernest Caithness and Mrs. Y. E. Caithness, of Berrisdale, Ealing.

Deaths.

- ALLEN.**—On Feb. 26th, at 3 Carlisle Parade, Hastings, Ella Louise Katherine, wife of Bryan H. Allen, M.D., and daughter of the Rev. R. H. Dover, late Vicar of Wisden, Yorkshire, aged 56 years.
- BROWNE.**—On Feb. 21st, Charles Browne, F.R.O.P. Edin., &c., youngest son of the late Tobias Browne, of Camberwell, aged 72.

Original Communications.

A TYPHUS FEVER OUTBREAK IN LONDON IN 1899.

By F. J. WALDO, M.A., M.D. Cantab., D.P.H.,
Coroner for the City of London; late Medical Officer of Health
for the Parish of St. George-the-Martyr, Southwark,
London, &c.

THE recent appearance of typhus in the East End of London reminds us that the disease in question is an ever-present danger. Typhus fever is so highly infectious, so deadly, and liable to so many variations in its symptoms that medical men will do well to refresh their minds with a review of its chief characteristics. Some years ago, while acting as Medical Officer of Health for a large and populous parish in South London, it fell to my lot to investigate the history of several cases of typhus fever in my district. The resulting record showing the train of infection and the pitfalls of diagnosis associated with unrecognised typhus, is so striking that I venture to republish my original report presented to the sanitary authority of St. George-the-Martyr, Southwark.

On February 28th, 1899, a case of typhus fever was notified to me as occurring at No. —, Southwark Bridge Road. On inquiry I found that the patient had come from Bermondsey suffering from the malady, and that several of her relatives had been attacked with mysterious illnesses. During 1898 two other cases of typhus fever occurred in this parish. The first of these was in April and was traced to Kensington, but did not spread in St. George's. The second occurred in October, and its origin could not be ascertained. Some of the members of the infected family went to a house in Bermondsey, where the disease subsequently developed. Under these circumstances it occurred to me that there might be a possible connection between the case notified to me last October and the one brought to my notice in February. On inquiry I found such a connection, and was enabled to trace the following interesting and suggestive train of events:—When the first case was notified I closed the house and induced all the inmates to enter the reception house, with the exception of the father, who went away and slept two nights at No. — (a), Minto Street, Bermondsey. This fact I at once communicated to the Medical Officer of Health of Bermondsey. In the house at No. — (a), Minto Street, there were resident four families. On or about December 15th, Mrs. F., a resident at No. — (a), was taken ill, and was admitted to Guy's Hospital on December 18th. She was there treated for supposed enteric fever, and was discharged to a convalescent home on January 22nd. The father's visit to No. — (a) was paid to his son and daughter-in-law, who on December 24th, 1898, removed to No. —, Tabard Street, Newington. On January 13th, 1899, the son was taken ill, and removed in a delirious con-

dition to Newington Workhouse, where he died on January 18th. The wife of the last patient was taken ill about the same date, and died at the aforesaid No. —, Tabard Street, on January 14th. Returning to No. — (a), Minto Street, we find that Mrs. F., who was first attacked there on the night before she went into Guy's, called at No. — (c), Minto Street, and arranged for one of her boys being taken there as a lodger. At the same time she interviewed a woman from No. — (b), who undertook to take charge of a second son. Towards the end of January the son, who had been left at No. — (b), Minto Street, was removed to St. Olave's Union Infirmary, where he still remains at the time of report (March 13th, 1899). Returning to No. — (c), Minto Street, we find it inhabited by the W. family—father, mother, three sons, and two daughters—and the recently admitted son of Mrs. F. Seven of these eight persons were admitted to hospital at various dates up to March 7th, and all these cases have been recognised, either at the time or subsequently, as typhus fever. The son, Richard W., was taken ill on January 14th, and admitted on the 19th to King's College Hospital, where he died on the 30th. The son, Frederick W., was notified as enteric fever on February 11th, admitted to Guy's Hospital, found later to have typhus fever, and sent to the South-Eastern Fever Hospital.

F.'s son was notified enteric fever on February 15th, sent to Guy's Hospital, also found later to be suffering from typhus fever, and dispatched to the South-Eastern Fever Hospital, where he and Frederick W. still remain. Mrs. W. was admitted on February 14th to the Park Hospital, where she is still under treatment. The father was notified as enteric fever on February 18th, and taken to Guy's Hospital, where he died on the 22nd. The daughter, Alice W., entered Guy's Hospital on March 4th, and was sent to the South-Eastern Hospital with typhus fever on March 6th. The son, George W., went into St. Olave's Union Infirmary on February 21st, and was removed with typhus fever on March 7th to the South-Eastern Hospital.

My own patient, Mrs. B., was notified on February 20th, from Guy's Hospital, as having resided at No. —, Southwark Bridge Road, in the parish of St. George-the-Martyr. She had removed to that address two days previously from No. —, Weston Street, Bermondsey. On inquiry, a direct communication with the group of cases at No. — (c), Minto Street, was established by the fact that she sat up one night with her brother, Richard W., while a patient at King's College Hospital, where he died, as already stated, on January 30th. Other cases doubtful in nature and origin are still under investigation.

On the strength of the above facts, I think we may be fairly justified in arriving at the following conclusions:—1. That there has been a direct

chain of communication between the two cases of typhus fever notified in the parish of St. George-the-Martyr on October 19th, 1898, and February 20th, 1899. 2. That the infection was carried out of the parish by the father of the first patient. Had he entered the reception house with the rest of the family in all probability the centre of original infection would have been stamped out.

In conclusion, I have to acknowledge the cordial assistance afforded me in the course of the above investigations by the authorities of the various hospitals, the Medical Officer of Health, and the local medical men concerned.

THE ETIOLOGY OF CARCINOMA: DOES IT PERFORM ANY PHYSIOLOGICAL FUNCTION? (a)

{ By GEO. THOS. BEATSON, C.B., M.D.Ed.,

Lieut.-Col. Royal Army Medical Corps; Surgeon to the
Glasgow Cancer Hospital.

SOME recent utterances, he said, favoured the idea that carcinoma was a microbic disease. To name only the latest researches, neither Doyen's work nor that of Ford Robertson and Wade had yet fulfilled Koch's criteria. If Doyen's serum actually had the specific curative reaction claimed for it then it would prove the correctness of the theory of the microbic origin of the disease. In the published accounts of cases treated by Doyen's method there is conspicuous absence of evidence of changes in the cancer-cells, and stress is chiefly laid on the increased mobility of the tumours. Such an increased mobility was only what was to be expected from the use of a serum, because a great part of the fixity of malignant growths was due to small-celled infiltration. A serum derived from microbic tissue might well influence favourably this small-celled inflammatory deposit, and by loosening and defining the boundaries of a neoplasm be a valuable adjunct to operative procedures, just in the same way as Watson Cheyne advocated the preliminary use of antistreptococcal serum in operations for excision of the tongue in order to diminish sepsis. The speaker was more and more inclined, however, to regard carcinoma as a tissue vice, and to advocate the germinal theory of its origin, a view to which he had been led by the remarkable results of oöphorectomy in mammary cancer. Analysis of the reported cases in which this had been done was favourable to the procedure. Hewlett's recent collection showed that not less than 36 per cent. of the cases had benefited. The result of oöphorectomy was an increase of the stroma of the tumour and a fatty degeneration of the cancer-cells—that is, conversion of the tumour into a fibro-scirrhous carcinoma. If the germinal theory of cancer were true, we ought to find among cancer cells signs of the activities characteristic of reproductive tissue, *i.e.*, extension of polar bodies and reduction of the chromosomes. With the assistance of Dr. Ernest Fortune, a number of specimens had been examined to this end, but they had not found unequivocal evidence of extension of anything like polar bodies, and on account of the great difficulties involved in the task no very prolonged search had been made for signs of reducing division. A series of observations had

been made on the effects of inoculating rabbits with testis and ovary, but without positive result. Confirmation of the germinal theory, however, had been recently afforded by Farmer's researches on mitoses in cancer-cells. It was important to remember that the cell was the essential feature of the carcinoma—not the stroma. The characteristic of the tumour was the fact that it was composed of large polygonal cells irregularly distributed, with no nerves, vessels, or lymphatics, and no tendency to organise like ordinary granulation tissue. The stroma consisted of the pre-existent elements, among which the cells were forced; such cells, of course, were prone to degenerate easily; they proliferated only to perish, and had no constructive power. Another evidence that cancer-cells were part of the tissues of the body and not microbic in origin was the fact that they were non-irritating, as was shown by the fact that local secondary growths did not reveal themselves by any signs until they had attained a considerable size. Hence in many cases delay in seeking medical advice was inevitable on account of the latency of the symptoms. Dr. Beatson, however, protested emphatically against the advice that in order that cancer might be recognised in its early stages information as to the symptoms of the disease in its incipient period should be disseminated broadcast. People should be taught to consult their medical advisers when definite symptoms arose, irrespective of what they were due to; but to raise the spectre of cancer in the minds of the laity by inculcating the doctrine that the most trivial signs might be due to malignant disease would be to superinduce a frame of mind in which anxiety and fear would actually go far towards producing what they wished to prevent. Some peculiar appearances noticed in the fat of cancerous patients were then mentioned. The bodies of cancer patients were sometimes strikingly well nourished, and the fat was highly pigmented and of the reddish-yellow colour of yolk of egg. This was possibly associated in some way with the lemon-yellow tinge of the cancerous cachexia. Again, he had often observed an oily fluid state of the fat at operations, and in these cases there was a greater tendency to dissemination of the growth than persons of spare habit. He had endeavoured, though without success, to elucidate the nature of this abnormal pigmentation; the chemistry of the pigments of human fat was a matter about which very little was known. In both the ovaries and testes the reduction of the chromosomes and extrusion of polar bodies preceded maturation of the germ cell, and maturation was accompanied by a rapid growth of cells. He took it that there must be in the body some stimulus to this reducing division and extrusion of polar bodies, and this stimulus he believed to be a fluid in the tissue juices; it might either be a secretion of some particular organ or of all the tissues. In castrated persons there was a tendency to the deposit of fat in the body; this he regarded as due to a storing up or diversion of this fluid from its proper end, namely, the stimulating of reproductive cells. The current view of cancer, that it occurred irrespective of the requirements of the body, was possibly not correct. It was a mere assumption that the proliferation of cancer-cells was autonomous; possibly cancer-cells functioned in place of others which had passed into a state of inactivity. Recent investigations on the rounded

(a) Abstract of Paper, specially reported for this Journal, at a meeting of the Edinburgh Médico-Chirurgical Society, March 1st, 1905.

bulbs or nodules on the roots of healthy bean and clover plants were specially interesting. These tumours or nodules varied from the size of a bean to that of a potato, and were found to be packed with bacteria, which were constantly absorbing nitrogen from the air and feeding the plant. This fact had been made use of in scientific agriculture by inoculating soils with these bacteria to increase their crop-bearing power. Here, then, was a tumour which played a beneficial part in the life of its host. Now, Farmer and his colleague had shown that cancer-cells revealed a reducing division, therefore they might assist, or even replace, the reproductive cells. Carcinoma had an action not unlike that of the testes and ovary; it was constantly throwing off cells, some of which proliferated, and others degenerated. Operation on cancer had some bearing on the view that the tumour was a secreting organ. If they were successful, the patient rapidly put on fat; this he supposed to be due to a cessation of the drain from the tissue of the procreative fluid used up by the tumour. The procreative fluid in the tissues which was not dealt with by the testes or ovaries, on account of their function having fallen into abeyance, or for other reasons, was stored up by the fat, but the fat could not go on storing it up indefinitely, and so at last it stimulated some of the body cells to take an activity analogous to that of the reproductive cells—that is, to become carcinomatous.

THE APPLICATION OF PLASTER OF PARIS FACILITATED BY ANEW APPARATUS. (a)

By W. I. WHEELER, M.D.,

Surgeon to Mercer's Hospital, Dublin.

THE application of plaster of Paris to recent fractures has gained favour, not only on the Continent, but also in London, and to a lesser extent in Dublin within recent years; however, whether plaster be applied immediately, or at any time subsequent to the injury before union has taken place, many difficulties arise in its application which are especially noticeable when it is intended to secure the entire limb and pelvis in a plaster casing when the femur is broken. For instance, it is impossible by the existing methods to fix the leg and pelvis in plaster of Paris with any certainty that the deformity has been accurately corrected, or that sufficient extension has been maintained to reduce permanent shortening to a minimum. During the operation two or three assistants were always essential, and when the pelvis was reached, the greatest awkwardness accompanied the hoisting of the patient off the bed or table at every roll of the bandage. With these manipulations it was unlikely by the time the plaster was completely on that the fragments had remained in proper apposition.

Various appliances have been thought of to overcome the difficulties enumerated above. The principles of the machine about to be described were suggested to my mind by a device described by Agnew twenty years ago, and also by the knowledge that various surgeons, notably Kocher, of Berne, and Doyen, of Paris, have appliances to aid them in the accurate setting of fractured femurs, and their results show many cases where no permanent shortening has existed. Even

(a) Read before the Surgical Section of the Royal Academy of Medicine in Ireland.

Agnew, by the device just alluded to, treated fractured femur by the primary plaster method, with results very rarely surpassed at the present day. His apparatus consisted simply in an upright bar well padded and fastened to the end of a table to receive the perineum. A horizontal bar attached to the upper end of this, extended backwards parallel to the patient; the latter was slung by a towel to this, so as to raise him slightly from the table, and thus to give easy access to the pelvis, which was encased in plaster of Paris, together with the entire limb on the fractured side. This machine, simple and easily extemporised, did not overcome the disadvantages of having to rely on an assistant to keep up extension during the application and subsequent drying of the plaster. Such extension is likely to be very inaccurate, and there is no guarantee that it is not relaxed at intervals, or that the two legs are ever exactly the same length. An error in this respect is rendered all the more likely by the fact that relative abduction and adduction of the two legs can usually only be roughly estimated. Indeed, obliquity of the pelvis is a factor likely in these cases to cause considerable error in estimating length.

A modification of Doyen's apparatus I have seen used allows free access to the limbs, but not to the pelvis. It registers abduction but does not provide for extension, and therefore fails to supply two of the most necessary requirements for the treatment of these injuries. Kocher's apparatus I have not had an opportunity of seeing in use. It is very perfect, but an expensive and somewhat complicated machine, fitted with a system of dynamometers, which ensure the greatest accuracy. It is necessary before describing the application of the plaster to call special attention to an elementary point, but one often disregarded, *i.e.*, that it is well worth while to make sure that the plaster itself is thoroughly reliable in all respects, because after an extensive application, and where much trouble has been taken to accurately reduce the fractured limb, it is most disappointing if the dressing is found defective, either failing to set or else cracking in the places where strength is most required. As an example of the latter, the groin may be mentioned, and it is wise to apply strips of aluminium or lead, or bits of sticks through the plaster in this region, to give it strength.

The apparatus (Figs. 1, 2, 3) is very simple and inexpensive. It consists essentially of two iron gates (E) about four and a half feet long, swung on an upright (B), which latter is surmounted by a padded crutch (A), so shaped that a small portion of the padded surface is horizontal (X), and will afterwards be seen to support the coccyx and lower part of the sacrum when plaster is being applied to the pelvis (Fig. 3). The crutch and upright on which it sits are supported by a heavy stand (C) with two diverging legs on each side drilled with holes, so that if required it can be screwed permanently to the ground; this, however, is not necessary. At the distal end of the gates can be seen a roller (D) over which the bandage is placed while extension is being applied. The roller is square on section in order to obtain a firm hold on the bandage, and also because, when sufficient extension is obtained, by gently pushing the handle inwards the square bar fits into a hole of the same shape and diameter, and so locks. By this means,

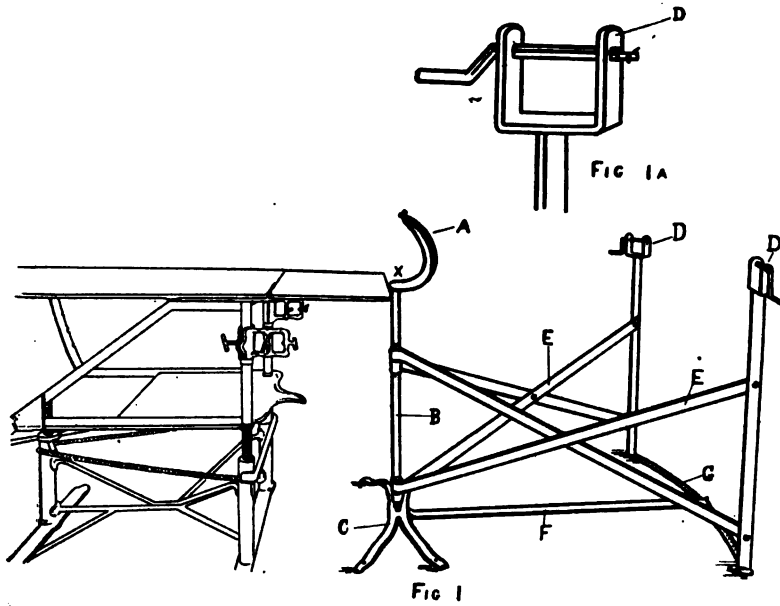


FIG 1

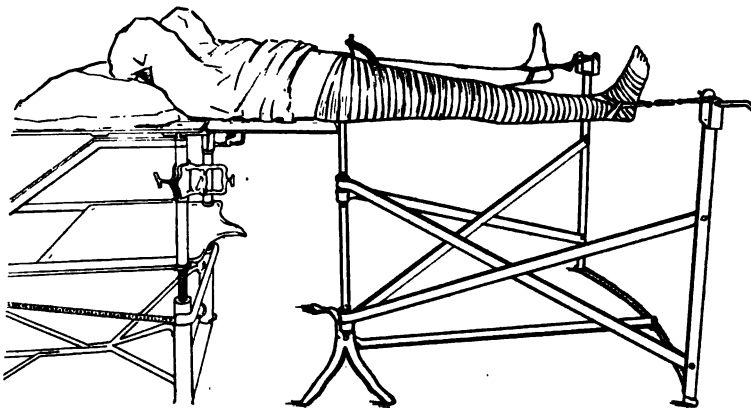


FIG 2

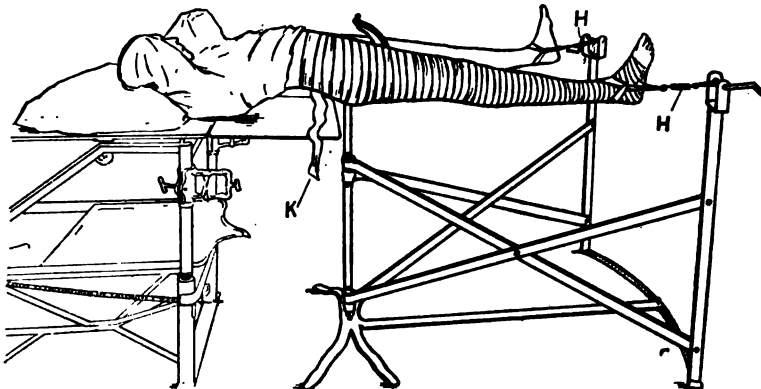


FIG 3

every quarter-turn the handle can be fixed, a simple substitute for a ratchet.

Now comes an important part of the machine, a bar (F) fixed to the stand and running at right angles to it between the two gates. To the end of this bar a graduated curved iron is attached (G), so that the gates can be diverged from the middle line each to a measured amount, and so the limbs abducted to the same extent. By this method there can be no obliquity of the pelvis.

To make the apparatus complete two Salter's sportsmen's balances are necessary, registering at least fifty pounds, so that by attaching these to the rollers the extension can be accurately measured, and the same amount applied on both sides if required (H).

I will now briefly describe the setting of a fractured femur on the new apparatus either immediately after the injury or at any time subsequently before union has taken place, according to the indications present. The patient being anaesthetised, the apparatus is brought to the end of the table, which is raised or lowered until the horizontal part of the crutch is level with the surface of the table (Fig. 1). If the table cannot be raised or lowered, it would be better to have the crutch fitted like a bicycle saddle in order to be able to make it any required height.

A clove hitch is applied to the ankle, the latter having been first well padded with wool, or, better, a skein of knitting wool is applied to the foot (figure 8 fashion) and fixed by a bandage, as recommended by Watson Cheyne. Either of these will do for extension purposes. A leather anklet with stirrups would serve the same object.

The patient is now brought to the end of the table astride the crutch (Fig. 2), the surgeon taking

charge of the injured limb. The skein of wool, or whatever is used, is attached by a bandage to the iron roller, the graduated balances intervening. Both legs having been thus fastened, the gates are opened to the same measured extent; this will vary in different cases. The limbs can now be accurately measured and extension put on by means of the rollers until both are equal; they are then securely held by the apparatus in this position. The plaster is rapidly rolled on, there being free access to the leg, until the pelvis is reached. The table is now lowered two or three inches, the coccyx and last bit of the sacrum are supported on the crutch, the back becomes arched, and a space remains between the table and the greater bulk of the pelvis, round which the roller bandage can be continued without any assistance, and little disturbance of the patient (Fig. 3). It is recommended not only to encase the injured limb and the pelvis, but also to continue the plaster down the sound limb as far as the knee, and thus secure the immobility of the pelvis, and provide counter extension at the perineum.

It is wonderful to see how well patients can walk with crutches, and even sit down after a fashion, with one and a half legs in plaster together with the entire pelvis, and it is safe to allow them to do this in many cases four or five days after the accident, provided the plaster be firm, and all the weight is kept on the sound leg; a bandage round the neck supporting the injured limb.

It must not be thought that this device is only of use to those who apply plaster as a primary treatment; it is hoped that it may also be of service to everyone who uses plaster of Paris at any period during the treatment of fractured thigh bones, and also during certain operations on the bones where extension is required and a plaster dressing used.

I have treated five or six cases in this manner with success in every instance; the plaster was rapidly applied, scarcely any assistance was necessary, and the patients expressed themselves free from pain and more comfortable than when a McEntire's splint or weight and pulley was used. An oblique fracture in an adult near the middle of the shaft is the most suitable case. In a great number there should be no permanent shortening in fractured femur, and there have been many such results in this country and abroad.

I am indebted to Dr. Haughton's paper read before the Academy two years ago for much information on this subject; and to Dr. Harnett, one of the house surgeons at St. Thomas's Hospital, London, for showing me many cases of fractured femur treated there by the primary plaster method.

One of the residents in Mercer's Hospital (Mr. Smith) was kind enough to act as model while photographs were being taken from which the accompanying illustrations have been made. Finally, it is quite obvious that some cases of fractured femur could not be treated by the method described, with the apparatus in its present form, but a few alterations which have been presented to me would make it, I think, suitable for almost every case.

Vaccination Grant.

MR. PHILIP E. HILL has been awarded for the fourteenth time in succession the Government grant for efficient vaccination in the Crickhowell district of the Crickhowell union.

ORGANISED AND SYSTEMATIC RESEARCH IN OTOLOGY. (a)

THE PRESIDENTIAL ADDRESS,

By THOS. BARR, M.D., F.F.P.S.Glasg.,
Lecturer on Aural Surgery, Glasgow University; Senior
Surgeon to the Glasgow Hospital for Diseases of the Ear.

AFTER thanking the members for the honour conferred on him by his election as President of the Society for the second year, he said: My first aspiration is the institution of organised and systematic research in connection with the Otolological Society. I would ask, is there any part of the body which presents problems so eminently demanding research as that with which we have to do? Difficult problems, complicated problems, we are sometimes apt to think insoluble problems. By means of organised and systematic research, we could grapple more closely with these difficulties and hope to solve at least some of them. As one subject well worthy of research I would suggest the further elucidation of the pathological conditions present in ear disease, especially in the dry, non-purulent middle-ear forms, by more thorough clinico-pathological methods, so as to help in differentiating their varieties more accurately; this differentiation being, I think, one of the main conditions of advance in treatment.

I am probably correct in saying that, since the time of Toynbee, the pathological anatomy of the ear has not received adequate attention in this country. There is probably no region of the human body so habitually ignored by the pathologist in the *post-mortem* room, and yet there is probably no part where it is so important in the interests of progress that such an examination should be made, and that thoroughly. The difficulty of the processes involved in both the macroscopic and microscopic examination of the ear and the apparent lack of any practical result commensurate with the trouble have, I fear, deterred many. The British type of mind is essentially a practical one, and is impatient to see definite and immediate fruit resulting from its labour. It may be held that the otologist himself should see to the examination of any specimen coming from his hands, but this is, with the most of us, impracticable, as the thorough examination of the temporal bone and organ of hearing requires more time and technical experience than fully-occupied otologists can usually command, while the operative work which now falls to the otologist renders it, perhaps, undesirable that he should engage in *post-mortem* work.

Might it not, therefore, be possible to make arrangements with gentlemen at important centres, say, young men having in view the practice of otology and duly qualified by pathological training for the work, by which temporal bones, sent by any member of this Society, might be examined anatomically and pathologically and reported upon? Instructions might be issued to members how to prepare such specimens for safe transmission, forms of questions might be furnished to elicit the clinical history of the person from whom the specimen was removed, when that is possible. Our dissections and specimens have hitherto lost much of their value owing to the

(a) Delivered at a meeting of the Otolological Society of the United Kingdom, February 6th, 1905.

frequent absence of such clinical records, and, if such an investigation were to be profitable, this lack must in future be supplied. With the knowledge that specimens would be thoroughly utilised, members would be more on the outlook for suitable prospective cases, perhaps putting themselves in communication with physicians in general hospitals or in parochial or workhouse hospitals. In this way members might become aware of appropriate cases in such institutions—such as patients suffering from fatal diseases, and at the same time the subjects of deafness or ear trouble. Those, when known, might be carefully examined clinically, so far as the ear and hearing are concerned, with the expectation that, if brought to the *post-mortem* room, the temporal bone or other implicated parts might be removed and subjected to careful examination under the light of the clinical records.

No doubt it might be difficult to find young pathologists fitted for this work. Such a pathologist must be specially interested in otology, and all the better if engaged in clinical work with the intention of following up the specialty. What a splendid foundation would a year or two of this work form for the life work of the future practical otologist.

I am afraid, however, that such a scheme, to be successful, would involve the expenditure of money. We have, unfortunately, no research fund, such as is possessed by the Odontological Society, but I believe there are sources from which funds could be obtained to aid in such research, if any of our members, or even suitable gentlemen outside the Society, were willing to undertake the work under the supervision and co-operation of this Society.

My second aspiration is the formation of a permanent museum of anatomical and pathological specimens, including also instruments, models and appliances for the teaching of otology, a place to which members might resort for leisurely inspection and study. Speaking as a member hailing from the distant provinces, such a museum would prove specially attractive. Those of us who live at a distance from London have sometimes a few hours to spare on the day of the meeting, as I had lately, when, having no museum to inspect, I placed myself under the courteous guidance of Mr. Bethell and surveyed the premises of the Medical Society. I was conducted for the first time to our library, which I am bound to say presented a very modest appearance, "cabined, cribbed, confined" within the limits of a few feet of shelving. In looking, however, at its very limited proportions, I reflected that many great things spring from small beginnings, and that these meagre shelves might present the "promise and potency" of a future great library. I confess, however, that I did not keenly feel the lack of a great library, because, after all, most of us have very little difficulty in procuring, wherever we are, any book we may desire. I felt that the contents of a museum were the books I should have liked to peruse during my hours of waiting. There is no doubt that our department lends itself to the production of anatomical and pathological specimens, both microscopic and macroscopic. The temporal bone itself is a perfect mine of possible specimens, without taking into account the neighbouring cranial, nasal and pharyngeal cavities. We saw what could be done in the splendid collection of the

memorable museum of 1899, a valuable and permanent souvenir of which is to be seen in the volume prepared by Mr. Arthur Cheatle and Dr. Jobson Horne. The only pity was that such a unique collection, gathered together with so much labour, was open to inspection for only one short week.

I am confident that, if we had a place for their reception, we would soon have a collection forming a great attraction to our members. There are many sources from which we might draw. For example, if research work were set agoing the museum would naturally become the home of the specimens resulting from research. Each of us, I am sure, would contribute something from time to time. Donations from outside workers would, no doubt, be forthcoming, when it became known that this is a feature of the Society. Legacies from private museums might also be looked for in time. It is even conceivable that the Royal College of Surgeons might hand over Toynbee's historical specimens, which would form a grand nucleus, as well as a stimulus to future workers. In such a museum I would look forward to a department for instruments, into which every member of the Society, who might devise something new, would be expected to place a duplicate. Other otologists, not members of this Society, might be disposed to do the same. Instrument makers, both at home and abroad, would, I believe, contribute to such a collection, and would, no doubt, if invited, be willing to show from time to time, perhaps on the days of our meetings, new instruments or appliances bearing upon our department. This would especially prove a boon to country members, who would thus be saved the trouble of visiting instrument makers' establishments in search of new and improved instruments. Even models, diagrams, casts, &c., might appropriately find their places in such a collection and be helpful, especially to those of us who are engaged in teaching. The possibilities of usefulness connected with such a scheme are almost limitless. If the gentlemen who did so much to make the London Museum of 1899 so striking a success would take this matter in hand, our museum would soon become an accomplished fact, and from a small beginning it would, ere long, expand, and I would not be surprised were it ultimately to reach the dimensions of that of 1899—a permanent source of interest and education to all otologists.

Clinical Records.

ROYAL FREE HOSPITAL.

Case of Prostatectomy and Lithotomy.

Under the care of Mr. JAMES BERRY.

[Reported by Mr. A. W. HOGG, House Surgeon.]

THE following is a short summary of the notes of a case of enlarged prostate in a man, æt. 67, who was sent up to the Royal Free Hospital on October 6th, 1904, by Dr. Franklin Eminson, of Scotter, complaining of painful and frequent micturition and frequent attacks of retention.

History.—About ten years ago patient began to have slightly increased frequency of micturition, especially at night. Two years later, after exposure to cold and damp, he suffered from retention, and for six months afterwards his urine had to be drawn off with a catheter. Since then there has been more or less urinary trouble, although now and again there have been intervals, sometimes as long as three months, of comfort. Pain has been present at times. Dribbling

of urine has been a marked feature of the case during the greater part of patient's trouble. Blood has been occasionally present, but this was attributed to catheterisation. The urine was noticed frequently to be thick and muddy-looking, and it was observed that at such times the pain was more severe. There is no history of stone or gravel. Family history good. Previous health good.

Urinary System.—The following are a few points concerning the urine: October 6th (day of admission), quantity, 16 ozs.; sp. gr., 1020; reaction, acid; pus present. 7th, quantity, 24 ozs.; sp. gr., 1020; reaction, acid; pus and stellar phosphates. 8th, quantity, 39 ozs.; sp. gr., 1015; reaction, acid; pus and stellar phosphates. 9th, quantity, 49 ozs.; sp. gr., 1013; reaction, neutral; pus and stellar phosphates; urea, 1.3 per cent. 10th, catheter specimen faintly acid; albumin, blood, and pus; urea, 1.45 per cent. Other systems quite normal. Temperature on admission, 97° F.; pulse, 64.

Local Condition.—On examination *per rectum* a round, smooth swelling, firm in consistence and without pain on pressure, was felt in the region of the prostate.

Diagnosis.—Simple enlargement of prostate and cystitis. The patient was at once put on acid sodium phosphate and urotropin.

Operation.—On October 15th, Mr. Berry did a suprapubic cystotomy. After washing out the bladder with warm boracic lotion, a few ounces of which were left in, likewise a silver catheter in urethra, an incision 3 ins. long was made in middle line of abdomen beginning just above the symphysis pubis. The peritoneum being pushed up, the bladder was exposed and opened by a vertical incision downwards. The catheter was at this stage withdrawn, and the operator's left middle and forefingers having been introduced into rectum, the prostate was pushed forwards. Mr. Berry then divided the mucous membrane over the prostatic growth and enucleated two adenomata—one a roughly globular mass, 2½ ins. by 2½ ins., the other somewhat larger and more irregular, with a diameter of 3 ins. Both tumours were encapsuled and weighed together 3 ozs. The bladder was next washed out and two large drainage-tubes, and also a gauze drain were inserted, reaching to the bottom of the bladder. Finally, a dressing of 1-2,000 bichloride of mercury was applied. The whole operation took eleven minutes.

Progress.—The patient had a rigor lasting ten minutes on recovering from anæsthetic, his temperature rising to 102°, pulse to 104. These, however, soon returned to normal. The gauze drain was withdrawn the same evening, and the bladder washed out with boric solution *per urethram*. The irrigation was repeated five times during the night.

On October 11th the bladder was irrigated five times. 12th and 13th.—Four irrigations in the twenty-four hours.

14th.—Three irrigations in the twenty-four hours.

15th.—Three irrigations in the twenty-four hours. Patient passed a small quantity of urine naturally.

17th.—Patient up for a few hours.

19th.—Irrigations twice in the day.

24th.—A little urine passed naturally—alkaline in reaction and containing some blood and mucus.

November 2nd.—Bladder irrigated once a day, but suprapubic wound dressed every eight hours as dressings got soaked with urine. One to four ounces passed naturally.

5th.—Catheter tied in, but could not be retained owing to difficulty in keeping it in place.

8th.—Drainage not being satisfactory it was decided to do a mid-perineal cystotomy.

11th.—**Operation:** The bladder having been first washed out, both suprapublically and *per urethram*, the wound in the prostate was scraped out and found to contain much granulation tissue, covered with much phosphatic deposit. From the bladder a piece of membranous-looking structure covered with phosphates was washed out. This was thought to be the sloughing remains of part of the prostatic capsule. A calculus about the size of a damson stone was also found and removed. The bladder was again irrigated thoroughly, and the

patient then put into the lithotomy position, and a mid-perineal section performed. A drainage-tube about 4 ins. or 5 ins. long and about ½ in. in diameter was introduced through this opening into bladder, which was again irrigated to see if drainage were quite free. The wounds, suprapubic and perineal, were dressed with gauze wrung out in 1-2,000 hg. Cl.

Progress after this operation was as follows:—

November 12th.—Bladder is being well drained through tube in perineal wound.

13th.—Perineal tube removed, but as drainage not quite satisfactory it was reintroduced and left in until November 23rd. The bladder during these ten or eleven days was irrigated *per urethram* every second day. The amount of urine passed every night about this time was about 16 ozs. to 22 ozs.; alkaline in reaction, and contained albumin.

November 28th and 29th.—As little or no urine had been passed naturally, Mr. Berry passed Lister's bougies 11-14 and 12-15 through urethra into bladder.

30th.—A catheter, No. 11, was tied into urethra and 32 ozs. of urine passed. The suprapubic wound was quite closed, and perineal was gradually becoming smaller.

December 9th.—Patient passed 2 ozs. to 3 ozs. naturally.

14th.—Patient passing nearly all his urine naturally; perineal wound nearly closed.

21st.—Patient went home quite well and with both wounds healed.

Except for some slight attacks of bronchitis the patient's general condition during his stay in hospital was extremely good.

On account of the alkaline reaction of the urine, patient had always beside him the following medicine:

Sodii acid. phos., 1 drm.;

Urotropin, 5 grs.;

Syrup limonis, 1 drm.;

Aq. ad 1 pint; t.d.s.

REMARKS BY MR. BERRY.

The chief interest of this case lies in the fact that besides the enlargement of the prostate there was a small calculus in the bladder which was not suspected or discovered at the time of the first operation. The value of urotropin and acid phosphate of soda in correcting alkalinity of the urine is well known. The patient was put on the above-mentioned mixture of these drugs several days before this operation and continued to take between two and three pints of it daily throughout his stay in the hospital. Nevertheless, his urine until after the second operation was never quite clear, and to this must be attributed the failure of the suprapubic wound to unite and the deposition of phosphates upon the prostatic wound. After removal of the calculus and the clearing away of the phosphatic deposits, the urine soon became clear, and the wounds healed up. It is well to note that acid phosphate of soda should be given in large quantities of water. Made up in the manner above mentioned, it forms a palatable drink like lemonade, and the patient should be encouraged to drink as much of it as he can, generally three or four pints per diem. In ordinary cases of simple prostatectomy, the urine can by this means be kept quite sweet and the wound in the bladder, if kept aseptic, heals readily. Another important point in the treatment of a patient after prostatectomy is to drain the bladder thoroughly for a few days by means of two large tubes in the suprapubic wound and to get the patient up early, if possible within three or four days of the operation.

Transactions of Societies.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD FRIDAY, FEBRUARY 3RD, 1905.

C. M. TUKE, Esq., President, in the Chair.

MR. J. D. MALCOLM read a paper on "Extra-Uterine Fœtation," and divided his observations on the subject

into *first*, a short description of the natural history of the condition; *secondly*, the points on which a diagnosis may be founded; and *thirdly*, the indications for treatment. Mr. Malcolm said that in a large number of cases of extra-uterine foetation a fairly certain diagnosis was possible from the history of the case alone. As a rule, menstruation is delayed for a week or two, or even a month or two, and then comes on irregularly, but cases are recorded where there has been amenorrhœa during the whole period of extra-uterine foetation. If, in addition to the irregularity just mentioned, a woman is seized by a sudden pain in the pelvis with symptoms of collapse, suspicion of extra-uterine foetation becomes almost a certainty. Severe hæmorrhage may occur before the patient has missed a period, in which case examination yields but little information, as the foetal sac is small, and the escape of blood makes the parts so soft that they can hardly be felt. If the blood escapes into the broad ligament, the uterus would be dragged and pushed upwards to the healthy side, but if the blood escapes into the peritoneal sac, it is very difficult and sometimes impossible to detect it. There may, therefore, be only the symptoms to indicate the condition. These are severe pain, vomiting, hæmorrhage and collapse. Under these conditions a definite diagnosis between a ruptured Fallopian tube and a strangulation or ruptured viscus is impossible, except by opening the abdomen. Later on, when a gestation sac can be felt, or when a clot forms, physical examination is important. When progress has advanced so far that the foetal parts may be defined, there should be no difficulty in diagnosis. With reference to treatment, Mr. Malcolm said that when profuse hæmorrhage is diagnosed there should be no delay in operating. The more serious the condition of the patient, the more urgent is the necessity for operative interference. The bleeding vessels are generally and most quickly secured by removing the ovary and tube. If symptoms are not urgent, the patient should be kept absolutely quiet in bed, and arrangements for an immediate operation made should hæmorrhage recur. If there is no further hæmorrhage, but a growing mass be found in the pelvis, operative treatment should be resorted to, but if a mass remains without any change of size, a further period of rest should be insisted upon. A considerable proportion of such cases will get well without surgical interference. When pregnancy is more advanced, and it is diagnosed that there is a living foetus developing outside the uterus, an operation should be undertaken without delay. If the foetus dies when pregnancy is fairly advanced, and there are no urgent symptoms, the question of operating may be open to discussion.

Mr. J. A. MANSELL MOULLIN could not accept Mr. Malcolm's views as to treatment of cases where a hæmatocele had formed, and considered that in all cases of pelvic hæmorrhage an operation should be undertaken, without waiting for the patient to recover after a lingering convalescence, with the danger of recurrence of hæmorrhage or suppuration. Mr. Moullin advocated waiting for the death of a foetus, when approaching maturity, before operating.

Dr. G. H. DRUMMOND ROBINSON agreed with Mr. Malcolm in his view that operation is not called for in every case of extra-uterine pregnancy in the early stage.

Dr. SEPTIMUS SUNDERLAND asked Mr. Malcolm in what proportion of cases under his notice he has observed that there has been no absence of menstrual flow. In his experience, the menses occurred regularly during the early months of extra-uterine gestation.

Mr. MALCOLM replied to Dr. Septimus Sunderland by saying that he was quite sure that menstruation is not *always* in abeyance until the tube ruptures.

Dr. F. J. McCANN delivered an address (illustrated by a large series of lantern slides) on the "Early Diagnosis of Cancer of the Neck of the Womb." A short description was given of the normal anatomy of the cervix and the importance of the "transitional area"—*i.e.*, where the squamous epithelium covering the vaginal portion joins the columnar epithelium lining the cervical canal—was especially emphasised as the starting

point of malignant growths. The subject was considered under two headings—(1) Cancer affecting the vaginal portion (portio vaginalis); and (2) cancer affecting the cervix proper. This distinction, however, is only possible in early examples of the disease, for the advent of ulceration alters the relationship of the different parts of the cervix. Three clinical types of cancer of the vaginal portion of the cervix occur. (a) The papillomatous or polypoid type, where a sprouting growth extending upwards into the vaginal canal originates by a somewhat broad base from the margin of the external *os uteri*. In this class is included the so-called cauliflower excrescence. (b) The infiltrating type, where the tissue of the vaginal portion is infiltrated with cancerous growth, one or both lips of the cervix being affected. (c) The superficial, flattened type prone to early ulceration. Here the growth creeps over the surface of the vaginal portion, and as there is a tendency to early ulceration a true malignant ulcer in an early stage is seen. Two special types of cancer affecting the cervix proper may be identified. (a) Superficial carcinoma of the mucous membrane of the cervix proper, characterised by the growth of papillomatous masses of different sizes in the interior of the canal, followed later by ulceration changes which hollow out the cervix and produce the characteristic crateriform ulcer, and (b) the infiltrating type where the walls of the cervix are infiltrated in part or in their entirety with cancer. This last type tends to spread rapidly to the lymphatics, and hence is frequently discovered when it is beyond hope of eradication. The early signs of cancerous disease are discharge and hæmorrhage. Discharge is the first sign, but hæmorrhage is the sign which prompts the patient to seek advice. It will be found that careful inquiry into the history of early cases will elicit the fact that an alteration in the quality and quantity of the leucorrhœal discharge is observed before any bleeding has occurred. For this reason all cases of discharges or a typical bleeding should be carefully examined and the *os uteri* inspected through a speculum. The signs elicited on examination are as follows: 1. Friability, a sign of great importance which can be tested by the finger nail, the curette, the uterine sound or a long probe. If there be much fibrous tissue present in the growth, friability may be entirely absent. 2. The occurrence of bleeding, the amount of which is entirely out of proportion to the extent of the injury inflicted. 3. The definite occurrence of new growths from the surface of the cervix, from the lining of the cervical canal, or in the substance of the cervix. The most common pathological changes in the cervix which may be confused with cancer are (1) Erosion. In the common erosion there is no ulceration. It surrounds the *os externum*, the edge is not sharply defined, but fades away into the surrounding mucous membrane. Epithelial islets and plugged follicles may be noted on the surface, and there is no infiltration of the base. (2) Chronic cervical catarrh in elderly multiparæ associated with fissures and hypertrophy of the cervical walls. The examining finger passes into the patulous cervical canal, whose lining is rough and furrowed with thickened, hard, cervical walls. On withdrawing the finger blood may be seen upon it. *Per speculum.* The mucosa of the cervix is smooth, shining, bright red, with total absence of any ulceration. It is only by firm pressure of the finger or sound that bleeding from the surface occurs, and above all, neither the sound nor the sharp curette can detach pieces from the cervical lining. If still in doubt, the microscope can be used.

A full description was given of the different varieties of ulcer met with on the cervix. The differential diagnosis from polypi and small myomata, distended follicles, &c., was given.

Dr. G. R. DRUMMOND ROBINSON pointed out that one of the most reliable signs of early cancer was the presence of friability of the suspected tissues.

Mr. DONALD ARMOUR asked Dr. McCann whether in cancer of the vaginal portion of the cervix he always

performed a pan-hysterectomy or is satisfied with supra-vaginal amputation.

Mr. CECIL H. LEAF wished to know Dr. McCann's opinion as to how much importance he attaches to the presence of ulceration, as he did not consider it a reliable guide.

Dr. McCANN emphasised Dr. Robinson's remarks as to the importance of friability being an early sign, and in reply to Mr. Armour said that he was still in favour of supra-vaginal amputation of the cervix in early cases of cancer affecting the vaginal portion, whilst he preferred hysterectomy for other forms. Dr. McCann, in replying to Mr. Cecil Leaf, said that apart from traumatism, a *genuine* ulcer of the cervix was either malignant, tuberculous or syphilitic, and as the last two were rare, cancer should be suspected.

THE SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

DR. EDMUND HOBHOUSE (Brighton) in the Chair.
MEETING HELD FRIDAY, FEBRUARY 17TH, 1905, AT
11 CHANDOS STREET, W.

Mr. N. BISHOP HARMAN showed a case of Unilateral Paralysis of the third and fourth cranial nerves, of congenital origin.

Dr. PORTER PARKINSON agreed that it might be due to an anterior poliomyelitis.

Mr. SYDNEY STEPHENSON pointed out that in some cases there was a marked history of heredity.

Dr. E. HOBHOUSE showed a child, æt. 5, with Hemiplegic Spasticity and Inco-ordination on the right side; weakness of the right arm was followed a year later by inco-ordinate movements of the leg; six months before any nervous symptoms appeared the child had convulsions. There was no optic neuritis and no mental impairment. The condition had remained stationary for the last eight months. There was considerable spasticity on the right side and it was almost impossible to obtain a knee-jerk.

Dr. F. PARKES WEBER showed a girl, æt. 12, with Chronic Joint Disease, Splenomegaly and Enlarged Axillary Glands. There had been a definite general reaction to tuberculin, and he regarded this as a valuable indication for treatment.

Dr. F. J. POYNTON showed a boy, æt. 8, with Chronic Arthritis which had begun, without apparent cause, three years before. The affection was most marked in the hands and feet. The course was characterised by relapses and fever, with a good deal of local pain. The axillary glands were enlarged, but no splenic enlargement had been found. Radiography showed no changes in the bones. The appearance of the fingers was that of rheumatoid arthritis.

Dr. EDMUND CAUTLEY showed boy, æt. 9, with early Osteomyelitis or Epiphysitis of the Upper End of the Femur. He was admitted to hospital on December 16th, 1904, as a case of rheumatic fever. The symptoms were pyrexia, leucocytosis, anæmia, unduly frequent pulse, and pain and swelling in the upper part of the left thigh. An exploratory incision on December 28th was negative in result. On January 27th, skiagram showed definite changes in the neck and upper part of the shaft, and in both trochanters. On February 8th, pus appeared under the scar of the exploratory incision and on re-opening the wound a probe passed down to bare bone. Dr. Cautley regarded the case as one of mild osteomyelitis, starting as epiphysitis of the great trochanter.

Mr. DOUGLAS DREW advised further exploration.

Mr. ARTHUR EDMUNDS showed a boy, æt. 7, with Syphilitic Arthritis of the Right Knee, forming a painless swelling, of two years' duration, which had markedly decreased under anti-syphilitic treatment.

Dr. C. A. SUTHERLAND showed a boy, æt. 12, with Syphilitic Arthritis of both Knees, of one month's duration and quite painless. The joints contained free fluid. There was no other evidence of disease. He stated that in his experience drugs had proved of little use and that the affection ran a prolonged course, ending in spontaneous recovery.

Mr. DOUGLAS DREW showed a case of Excision of both Hip-joints for Tuberculous Disease and one of Acquired Club-foot with marked hereditary tendency.

Dr. E. PRITCHARD showed a child, æt. 2, with Spastic Diplegia and Optic Atrophy. The head was microcephalic. Labour was difficult and prolonged. Spastic rigidity was almost universal and almost constant choreiform movements were present in the hands and arms. Frequent mild fits occurred. The first fit was said to have been on the third day of life. There were no signs of intelligence. He regarded the condition as one of microcephalic congenital idiocy due to arrested or perverted development of the nerve elements.

Dr. HOBHOUSE showed a specimen of Congenital Absence of the Gall-Bladder and Bile-Ducts from a female, æt. 8 months, jaundiced since birth. Urine contained no bile salts or pigment. Fæces were white. The liver weighed 8 ozs. and the child 9 lbs. at death. There was marked interlobular cirrhosis.

Dr. HOBHOUSE also read a paper on a case of Interstitial Nephritis, with extensive Renal Retinitis, in a girl, æt. 6. The eye symptoms appeared two months before death, and were very intense. Urine was rather copious, contained a few hyaline casts and blood for a time. There was no evidence of congenital syphilis, but the child had had scarlet fever at the age of three. The kidneys were exhibited.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY. MEETING HELD MARCH 1ST, 1905.

PROF. JOHN CHIENE, C.B., President, in the Chair.

DR. GEORGE THOMAS BEATSON (Glasgow) read a communication entitled "The Etiology of Carcinoma: Does it Perform any Physiological Function When Present in the Human Body?" a full abstract of which will be found in another column under the heading of "Original Communications."

A long discussion ensued on the conclusion of this interesting paper, in which Professor A. R. Simpson, Dr. McBride, Dr. Taylor, Mr. H. J. Stiles, Professor Chiene, Dr. Ritchie, and Dr. Wm. Russell took part.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

A MEETING HELD IN THE MEDICAL SCHOOL, SHEFFIELD,
ON FEBRUARY 17TH, DR. LLOYD ROBERTS, PRESIDENT, IN THE CHAIR.

MULTIPLE PAROVARIAN CYSTS WITH UTERINE FIBROID.

Dr. S. BUCKLEY showed a fibroid the size of a hen's egg, enucleated from the uterus, together with both appendages, removed on account of ovarian pain and enlargement. In close proximity to each ovary there was a cluster of small cysts which were clearly of parovarian origin.

DERMOID CYSTS OF THE OVARY.

Dr. FAVELL showed an ovarian dermoid as large as a seven months pregnant uterus. It presented two well-formed teeth and a mammary gland with a nipple, together with a large quantity of hair. The patient had menstruated regularly, but had suffered pain during the last six months.

Dr. SINCLAIR WHITE showed an ovarian dermoid removed from a girl, æt. 13, who had never menstruated. It was generally adherent and the pedicle was twice twisted.

HÆMORRHAGE NEAR THE MENOPAUSE.

Dr. A. J. WALLACE instanced three cases. The first patient, æt. 50, had a sanguineous discharge for nine months. Cancer of the body was discovered and vaginal hysterectomy was done, facilitated by Schuchardt's vaginal incision. The speaker had been troubled by suppuration in this incision in several cases, and, in two, had seen rapid recurrence of cancer in the scar. The second patient, æt. 53, had ceased to menstruate for four years, when discharge began, and some months later the uterus was removed by the abdominal route,

the vagina being very narrow. The condition was again cancer of the body. The third patient, *æt.* 51, had suffered from menorrhagia for six years. The enlarged uterus at one time reached the umbilicus, but three weeks later was found to be considerably reduced in size, although no mass had been expelled from it. Vaginal hysterectomy was done, the large uterus being delivered by means of free vaginal incisions. The uterine walls were found to be thickened by a layer within, and distinct from, the original uterine wall, composed of fibrous trabeculæ enmeshing masses of muscular tissue.

The PRESIDENT would have preferred the abdominal route in the third case.

Dr. DONALD had given up the use of vaginal incisions in hysterectomy and preferred to reduce the tumour by morcellation.

Dr. GEMMELL had also observed suppuration in Schuchardt's incision and rapid recurrence of cancer in the scar.

ECTOPIC PREGNANCY.

Dr. BUCKLEY showed a thick-walled cyst of the outer portion of the Fallopian tube which contained blood clot, and was lined by a layer of granulation tissue. The diagnosis lay between ectopic pregnancy and hæmatosalpinx of inflammatory origin. The history suggested the former, but no chorionic structures could be found on microscopic examination.

ABDOMINAL MYOMECTOMY FOLLOWED BY PREGNANCY.

Dr. A. DONALD reported the case of a patient, *æt.* 31, on whom he operated for the relief of pain and hæmorrhage. There was a single soft fibro-myoma, as large as a cocoanut, growing from the uterus into the left broad ligament. It was enucleated without opening the uterine cavity, the bed being closed by both buried and superficial sutures. Two years later the patient became pregnant and was naturally delivered in due course of a healthy child.

ANOMALOUS UTERINE TUMOUR.

Dr. DONALD mentioned the case of a woman, *æt.* 40, who had a hard lump in the hypogastrium for two years, which recently caused acute pain and rapidly increased in size. On operation the hard fibroid uterus was found to be surmounted by a softer growth emerging in fan-shaped manner from the fundus. This vascular, deep red tumour proved to be a spindle-celled sarcoma, while the uterine tumour was an ordinary fibro-myoma.

HYSTERECTOMY AT THE SIXTH MONTH OF PREGNANCY.

Dr. FAVELL showed a uterus with sixth month fœtus and containing two large subserous fibroids in the lower uterine segment. The patient was *in extremis* with pressure symptoms, jaundice and albuminuria, when the operation, the only one possible, was performed, and recovered very rapidly.

PRIMARY SARCOMA OF THE OVARY.

Dr. GEMMELL narrated two cases of very malignant and rapidly recurring ovarian sarcoma in young women. The first, *æt.* 17, gave a history of three weeks abdominal pain and swelling. A hard, solid growth reached the costal margin and bulged into the pelvis. It was completely removed, but in three months the patient was readmitted with a large soft recurrence. This affected the mesentery and omentum and was scooped out by hand, but was beginning to reappear a month later. The second patient was *æt.* 20, and complained of two months' pain, wasting and weakness. An abdominal swelling reached above the umbilicus, and there was an irregular mass behind the uterus. On opening the abdomen blood-stained serum escaped, and after removing the ovarian sarcoma, deposits in the pelvis were found which could not be completely extirpated. There was rapid increase in the growth during the patient's recovery from the operation.

NORTH-EAST LONDON CLINICAL SOCIETY.

MEETING HELD THURSDAY, MARCH 2ND, 1905.

Dr. R. MURRAY LESLIE, President, in the Chair.

Mr. A. DE PRENDERVILLE read a paper on some ANÆSTHETIC DIFFICULTIES AND HOW TO COMBAT THEM, which will appear in a future issue.

The PRESIDENT, in congratulating the author, remarked upon the comparative frequency of post-anæsthetic pneumonia, and he considered, in view of the fact that the pneumococcus had been found in about 65 per cent. of healthy mouths, that some of the cases might be due to direct infection from inhalers or to the acquisition of virulent properties of the germ, which flourished in a mucous membrane whose resistance was lowered from the irritation of the anæsthetic.

Mr. ALEC. H. BREWER (introduced) referred to the so-called "chloroform sleep," which might well be classed as an anæsthetic difficulty. He had met with several instances of this condition, which was apt to prove deceptive, for bystanders usually remark that patients in this state "are taking it beautifully," whereas true anæsthesia is seldom present. Children were most often affected in this way by chloroform, the pupil being small and the corneal reflex abolished, but the respiration was not automatic. With regard to the tendency of bronchitis often met with in ether anæsthesia, he had found a combination of oxygen with ether very useful as a prophylactic.

Dr. F. J. TRESILIAN (Enfield) inquired if sudden oedema of the lungs was common after ether, as instanced by Dr. Murrell, and he related an unfortunate experience with somniform in a dental case.

Dr. A. J. WHITING considered that the recent work of Emby and Martin marked an epoch in the progress of anæsthetics. He had been, like many others, brought up in the creed that chloroform was the most convenient anæsthetic, but if it were now a question of having to regulate the percentage of the vapour, it would become altogether a different matter. Indeed, it would almost appear that chloroform should never be used again, in the light of recent research!

Dr. ARTHUR E. GILES thought that the operator should, at least, have some choice in the matter of what anæsthetic should be employed in a given case, but in many instances this was better left absolutely in the hands of the administrator. For his own part, he preferred ether as a routine anæsthetic, as tending to minimise the rise of blood pressure and consequent late hæmorrhage which sometimes followed the administration of chloroform in severe gynæcological operations.

Dr. E. HOOPER MAY recalled the time when there was no other anæsthetic in use but chloroform, and he never saw any bad results ensue from the "bold" method of administration then advocated by the Edinburgh School, even in the dental posture.

Mr. HERBERT CARSON considered that there was an added risk of giving an anæsthetic in the upright position in throat operations, and he referred to the special difficulties encountered in such major operations as those performed for cerebral compression for abscess and for intestinal obstruction. In the former case, the breathing not infrequently stopped quite early in the operation, while in the latter he had known grave risk incurred from the regurgitation of gastric and intestinal contents into the air-passages.

Mr. C. F. HUTT referred to the difficulties met with in anæsthetising patients when in the lithotomy position. As a general rule, he preferred a mixture of chloroform and ether. Mr. DE PRENDERVILLE replied.

France.

[FROM OUR OWN CORRESPONDENT.]

Paris, March 5th, 1905.

INFANTILE BRONCHO-PNEUMONIA.

BRONCHO-PNEUMONIA is a much graver affection than pneumonia in children, generally secondary, as a complication of small-pox, grippe, diphtheria, typhoid fever, or measles. When children are affected by any of these maladies, rigorous antiseptics of the natural orifices should be enjoined. In children of a certain age antiseptics of the nasal fossæ will be obtained by inhalations of—

Menthol, 3 grs. ;

Boric acid, $\frac{1}{2}$ dr.

For one powder, dissolved in an infusion of the leaves

of the eucalyptus tree and inhaled through a funnel. In young children, these inhalations can be replaced by instillations of—

Menthol, 20 grs. ;
Oil of sweet almonds, 2 ozs.

The mouth should be frequently rinsed with a solution of boric acid, and the eyes bathed with the same liquid, while oxygen water reduced to half strength should be instilled into the ears. With such precautions, says Professor Vidal, the lungs may be kept clear of infection.

When in the absence of such prophylactic measures, or in spite of them, broncho-pneumonia does set in, the treatment varies according to the intensity of the disease. If the child is not too depressed a vomitive will clear the large bronchi of mucosity, but if dyspnoea with tendency to cyanosis be present, a teaspoonful of the following mixture every hour should be given:—

Acetate of ammonia, $\frac{1}{2}$ dr. ;
Rum, 4 drs. ;
Syrup of ether, 4 drs. t ;
Water, 3 ozs.

To control the fever cryogenine might be ordered:—

Cryogenine, 20 grs. ;
Rum, 4 drs. ;
Syrup of tolu, 4 drs. ;
Syrup of cinchona, 4 drs. ;
Water, ad 4 ozs.

A dessertspoonful three or four times a day.

Hydrotherapy is one of the best means we have of treating broncho-pneumonia. The wet sheet, warm or cold baths, according to the judgment of the attendant.

The wet sheet might be renewed four or five times a day and left *in situ* for half an hour.

Balneation is recommended by all authors.

Labadie and Lagrave advise cold baths (77° F., and gradually reduced to 64° F.), in which the child is left five or ten minutes, and then rubbed vigorously to produce reaction and finally enveloped in a blanket.

The warm baths, on the other hand, should be given at 100° F., in which the patient remains from ten to fifteen minutes. Cold should be applied to the head while the child is in the bath to prevent cerebral congestion. In cases of collapse, mustard should be put in the bath.

Revolvives consist in mustard poultices and small blisters left on four hours and renewed.

As to a curative method, none has yet been found. Netter appears to have obtained good results from

Collargol, 30 grs. ;
Vaseline, 3 drs. ;
Lanoline, 1 dr.

Rubbed into the axilla or the groin for about fifteen minutes, then wiped off and the place covered with oiled silk.

If at the end of a month or six weeks the patient has not quite recovered, tonic treatment should be ordered and the air cure.

TREATMENT OF ACUTE CORYZA.

Phenic acid, 1 dr. ;
Liq. ammonia, 1 dr. ;
Proof spirit, 2 drs. ;
Water, 4 drs.

Pour 20 drops on blotting paper and breathe the vapours through the nose every hour.

Or—

Boric acid, 1 dr. ;
Menthol, 10 grs. ;
Cocaine, 5 grs. ;
Proof spirit, 5 drops ;
Talc powder, 2 drs.

To be used as snuff.

Iodide of sodium, 1 dr. ;
Syrup of bitter orange, 1 oz. ;
Syrup of lemons, 1 oz. ;
Water, 6 ozs.

A tablespoonful three times a day in milk.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, March 5th, 1905.

At the Society for innere Medizin, Hr. Langstein gave an address on

DIABETES IN CHILDHOOD.

It was a very infrequent occurrence, as he had only seen 8 cases in Heubner's Klinik between April 4th, 1904, and the present. The first case was that of a little girl, *æt.* 1 $\frac{1}{2}$, who had been treated in several polyclinics. The mother said the child had fallen out of bed twice about two months before, and had fallen on her head. Two days later the child seemed tired, and a slight cough came on. There was slight mischief at the apex of one lung, and the temperature was 38.1° C. She also said that the child was very thirsty, and that she drank about 2 $\frac{1}{2}$ litres of milk a day. Sugar was present in the urine. She would not allow the child to remain in hospital, but permitted examination of tissue changes to be made at home. It was ascertained that with the diet of 2 $\frac{1}{2}$ litres of milk the urine amounted to 5 $\frac{1}{2}$ litres, with 7 to 9 per cent. of sugar, together with a large quantity of acetone and acetic acid. In the first four days 200 and 250 grammes of sugar were excreted, and 14 grammes of oxybutyric acid. Butter-milk was given to reduce the quantity of oxybutyric acid, which was, in fact, reduced to 2 to 3 grammes in the 24 hours. As strict dieting was not practicable, oatmeal was substituted for the carbohydrates, and the quantity of sugar fell to 70 to 80 grammes, but the reduction could not be carried further. The child died of diabetic coma. The quantity of ammonia excreted was very large, 45 per cent. of the whole nitrogen consisting of it.

The second case was that of a child, *æt.* 3 $\frac{1}{2}$. There was no history except that after a fall on the head it had become sleepy and dull, and that since that time it had suffered from hunger and thirst. The urine excreted was 3 to 4 litres daily, containing 5 per cent. of sugar, and acetone and acetic acid. Here, also, oatmeal was given with good results so far that it again became lively and played. The hunger, however, continued so that the child used to go round to the neighbours to beg bread. Three and a half months later it also died in diabetic coma. There was no heredity in either case.

The next cases were not so carefully examined. They were two children, *æt.* 5. The thirst and hunger were relieved by the oatmeal diet, but they died in diabetic coma. Another child, *æt.* 7, had 4 per cent. of sugar in the urine; he died in 4 $\frac{1}{2}$ months. One case was interesting as showing heredity. The father died of diabetes, *æt.* 32, a sister also died of the disease *æt.* 5. The proportion of sugar was 2 per cent. Without any special diet the quantity of urine fell, and it contained no sugar. On the 5th, afterwards, 2 per cent. of sugar was again excreted; it then disappeared, and since then had not reappeared.

In one case recovery was observed. A little girl, *æt.* 7, was admitted suffering from thirst. There was no trace of injury or heredity. The quantity of sugar was always from 1 to 2 per cent. Then 100 to 150 grammes of oatmeal were given, and the proportion of sugar gradually fell to 0.4 and 0.1 per cent. In the last fortnight no sugar had been excreted, although carbohydrates had been given.

In one case observed by a friend the child took pneumonia when the sugar disappeared and it did not return. The disease was not always easy to diagnose in infancy. The ordinary tests were not trustworthy, the only certain one being Fischer's. There was a condition in infancy that simulated diabetes, *viz.*, enterocatarrh. Here, with a milk diet, sugar was always found in the urine in large quantities, but it was not grape sugar, but sugar of milk; it was lacturia, and not glycosuria. Milk fat was to be looked upon as the source of the acetone.

As regarded treatment, the speaker had acquired the impression that oatmeal could be given with advantage

when the other carbohydrates increased the quantity of sugar.

Hr. Litten saw a number of cases in 1880 that gave the impression of diabetic coma, but there was no sugar in the urine, only acetone and acetic acid. He had described these as cases of coma dyspepticum. Cataract developed with enormous rapidity in infantile diabetes.

Hr. Magnus-Levy said infantile diabetes was very fatal and generally quickly so. He wished to know if, in order to avoid the formation of oxybutyric acid, when the fat in the food was limited as much as possible and carbohydrates withheld entirely and albumen partially, what was to be given? The assumption that when more fat was given more oxybutyric acid was formed was not a correct one.

Hr. Mohr had had very good results with oatmeal treatment of diabetes, but it was of importance to give no other carbohydrates at the same time. His cases increased in weight under the diet. His experiments showed that albumen participated in the formation of sugar. Acetonuria occurred under various conditions. One cause was the too strict withholding of carbohydrates.

Hr. Huschfeld said that Fischer's test for sugar was too searching; it even showed traces of sugar in healthy people. Too much buttermilk should not be given as a sufficiency of fat was thereby excluded. He had seen both good and bad results from oatmeal treatment, but it ought to be tried. As regarded heredity, it was not always connected with diabetes amongst relatives, but it was not infrequently related to psychic affections.

Hr. Heubner remarked that Litten's dyspeptic coma was not identical with that of entero-catarrh. The one was easily curable, the other was always a symptom of serious poisoning, and the prognosis was always unfavourable.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, March 6th, 1905.

HYDROCYSTOMA.

At the Gesellschaft Riehl exhibited a female, *æt.* 56, with what he designated Robinson's disease, having been first described by this author in 1886 as a distinct skin affection under the name of hydrocystoma.

The patient suffered from unilateral facial hyperidrosis along with the uncommon condition of diffuse cysts which anatomically depend upon a pathological dilatation of the sudatory ducts. He thought the true etiology of the disease depended on an altered state of the gland or functional activity.

This view, he maintained, was supported by its occurrence on the face in washer-women, who were exposed to steam and heat that would excite the disease. The malady soon subsides without any bad effects.

CHOLELITHIASIS.

Bakes demonstrated a few preparations which he had taken from sixteen operations for cholelithiasis. The chief principle of his treatment was to operate at the earliest opportunity as soon as the pathological changes in the gall-duct were recognised, that all concretions should be carefully removed and adhesions separated to avoid any abnormal communications, and that drainage and tampons should be carefully carried out. He advises operation in all chronic closures of the chole-dochus, but acute forms of the disease should be avoided. The hepatic drainage apparatus of Kehrs is an essential equipment for all gall-duct surgery.

RADIO-ACTIVITY OF THE GASTEIN THERMAL BATHS.

Mache gave the members a long description of the beneficial effects obtained from the thermal waters in Gastein, which have recently been under discussion at the Kaiserlichen Akademie of Science. In this water it has been discovered that the emanations of radium are the chief virtues of the bath. In the discussion that followed Neusser was of opinion that Gastein water could be artificially prepared. He had himself obtained Urana pitch-blende from Joachimstal

in Bohemia, and produced a similar radio-active water. According to the analysis of the Gastein water the presence of this substance is found to be 0.000496 grms. in weight. Now, if five kilogrammes of this Urana pitch-blende be so spread over a bath that its emanations can be utilised, the therapeutic radium effect of Gastein water can be obtained. This same substance, pitch-blende, can be applied in the form of stupes or poultices by wrapping the pitch-blende in pieces of cloth. He had applied the substance in this form to two severe cases of tuberculous peritonitis with perfect success in relieving pain and rapidly absorbing the exudation. In another case of intercostal neuralgia he records a similar happy result. It may not be well known to all the members that in Joachimstal rheumatism is supposed to be charmed by this water, and certainly it produces a very happy result in those affected.

Urick said that the waters of Gastein did not of themselves contain all these virtues, as the surroundings, elevation, climatic changes, temperature of bath with the other constituents of the water, with, no doubt, a little suggestive treatment, were all beneficial factors in the curing of the disease. He quite concurred with Neusser in his artificial results. He had personally treated 3,000 cases at Gastein with only 10 per cent. of reactionary phenomena. These activities might be summarised as increased pain in the tabetic and neurasthenic, with disturbance of the sensorium, cardia and menstruation. Aggravation of the disease or skin eruptions were rarely to be observed. In all these disturbed cases he could not specifically point to radium emanations as the real cause, but would not at the present time venture to deny that such existed, as the thermal effects of the water can be identified with the results obtained from radium emanations.

LYMPHATIC LEUCOCYTHÆMIA.

Gerber showed a case of leucocythæmia which he had treated with Röntgen rays with perfect success. The rays were applied directly to the swollen lymphatics which rapidly subsided, and at the same time the number of leucocytes in the blood were gradually reduced. The only explanation that can be given is that the rays immediately check the formation of the lymphatic cells in the glands. The effect is not slow and gradual on the blood, but rapid and can be observed a few hours after application.

Holzknrecht remarked that he could confirm Gerber's observation from eleven cases which he had treated in a similar manner. Besides these cases mentioned he only knew of twelve others in the literature of the subject. There is another case recorded of myeloid lymphatic leucocythæmia with an upward curve of leucocytes at the beginning of the treatment which subsequently fell to a subnormal condition.

The Operating Theatres.

ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.

PIECE OF STEEL INSIDE THE EYE REMOVED BY MEANS OF HAAB'S ELECTRO-MAGNET.—Mr. H. WORK DODD operated on a man, *æt.* 26, an engraver from Woolwich Arsenal, who had been admitted to the hospital suffering from an injury to the right eye. The patient stated that, whilst working, a piece of steel flew up and hit him on the upper lid. On admission, there was a wound in the upper lid at the junction of the middle and nasal thirds, about six millimetres from the ciliary border; on everting the upper lid a corresponding wound was found on the conjunctival surface. There was also a wound in the eyeball corresponding in position to the wound in the lid, situated four or five millimetres from the corneo-scleral junction. This, Mr. Dodd pointed out, seemed to indicate that the foreign body had consider-

able force and velocity to penetrate through the thickness of the lid with its cartilage, the conjunctiva, and the sclera. The wounds were all about the size of a small pin's head. When the house surgeon first saw the case, some three or four hours before the operation, blood was, on ophthalmoscopic examination, beginning to be poured into the vitreous chamber, and he fancied he could see something which might have been the foreign body situated in the upper and inner region of the vitreous chamber. When Mr. Dodd examined the eye with the ophthalmoscope, the eye was too full of blood to allow any details to be seen; the lens appeared to be clear and normal. In view of the history being so definite, he thought that he might try the effect of Haab's big electro-magnet. This magnet, situated on a kind of heavy wooden table, is about a foot and a half long and six or eight inches in diameter. It appears to be composed of coils of wire tapering off into metallic cones at each end, and is of great weight. It rotates horizontally easily on a hinge so as to move in any direction, and is connected with the electric power of the hospital, the application of this last being controlled by a pedal apparatus. The magnet is evidently one of great power, as a bunch of keys thrown a few inches from it is immediately seized and brought into contact with it, and it is necessary, as Mr. Dodd remarked, for the surgeon and his assistants to leave their watches outside the room, otherwise the watches would certainly be thrown out of order by the magnetic current. The patient was seated on a stool which could be raised or lowered so as to bring his eye opposite and close to the cone apex. The magnet was first applied several times to the wound in the sclera, but this proved to be ineffectual. The patient was then told to look directly at the cone, the eye being brought almost in contact with the instrument. As the foreign body had appeared to lie in the upper and outer part of the vitreous chamber. Mr. Dodd thought that it might be brought forward into the anterior chamber by this means. The eye being in this position, the power was several times taken off and then applied suddenly, so as to move the foreign body by jerks, if possible; after this had been repeatedly done, Mr. Dodd pointed out that the iris bulged forward at a point corresponding to its upper and inner quadrant. The magnet being next re-applied, the iris protruded again at a lower point, showing that the foreign body was gravitating to the inferior part of the eye. By moving the eye in various directions Mr. Dodd now hoped to bring the foreign body out through the pupil into the anterior chamber, but this he was unable to do, as the foreign body seemed to catch itself at the back of the iris at the lower and inner quadrant, and there could be seen trying to force its way, whenever the current was applied through the base of the iris. At this stage, the patient, still being in proximity with the acting magnet so as to hold the foreign body in its present position, after cocaine had been applied to the conjunctiva, Mr. Dodd made an incision into the corneo-scleral margin as near as possible to the foreign body. The iris then showed a tendency to protrude through the wound, being pushed forward by the foreign body; therefore Mr. Dodd, with a broad, sharp needle, made a hole through the base of the iris on to the foreign body, which last he had the satisfaction to see come forth on to the cone of the magnet, leaving a small piece of

iris protruding from the wound; this was immediately restored to its proper position by means of a blunt probe. The foreign body proved to be a flat, triangular, thorn-shaped piece of steel just under half a centimetre long, its base being about two millimetres in width. The patient behaved admirably all through this trying ordeal. Mr. Dodd said that this was particularly satisfactory, as, considering that if the foreign body had not been found and removed in this way, the patient must undoubtedly have lost his eyeball; in fact, in the old days, before this magnet was introduced into ophthalmic surgery, the eyeball would have been removed at once by the surgeon, for the extraction of the foreign body by any other means would have been practically hopeless. He pointed out that the penetrating wound was unfortunately in the region of the ciliary body, really in the middle of it—that is, it was situated in the so-called dangerous area—and all ophthalmic surgeons know that penetrating wounds in the "dangerous area" were apt to lead to trouble in the way of cyclitis, septic inflammation, and even on to sympathetic iritis of the other eye, so that, although this present operation had been successful as far as the removal of the cause, *i.e.*, the foreign body, was concerned, the patient was a long way from being as yet out of the wood. In his favour was the fact that this foreign body was clean—practically aseptic—being in all probability a portion of a polished tool, and, again, as, having passed through the whole thickness of the lid and its cartilage, the conjunctiva and the sclera, &c., it had been to all intents and purposes wiped and cleansed *en route* before arriving at the interior of the eye. With regard to the application of the magnet, he had always been under the impression that it had been generally found easier to endeavour to remove a foreign body by bringing it from the back of the eye to the anterior chamber, and then making an incision and finally extracting it through the incision, than to endeavour to enlarge the original wound and to try to bring the foreign body out through its point of entry. This impression, he said, seemed to be amply corroborated by the present case. He would have been better pleased, however, if he could have brought the foreign body in this case through the pupil instead of having to make a wound through the iris. The route of the foreign body, influenced by the magnet, was, he thought, peculiar, as one would think the shortest way for it was through the centre of the lens instead of round through the peridental space, the probable explanation of this being that it followed the direction of least resistance—sliding off the curved back of the lens and coming round its edge through the suspensory ligament into the anterior chamber. The reason that it caught in the iris was probably due to the thorn-like shape of the foreign body, which caused it to entangle itself in the meshes of the back of the iris. Mr. Dodd casually mentioned that three brief excellent articles on the subject by Haab, Snell, and another could be found in the last number of the *Ophthalmoscope*.

A fortnight after operation the patient was discharged cured, the vision six-ninths, the eye perfectly quiet, and only a little deformity to be seen, the wound at the base of the iris having healed.

An Epidemic of Measles.

NOTTINGHAM is suffering from a scourge of measles. The exact number of sufferers is not known, but it is certain that some hundreds of children are affected, and the virulence of the epidemic is shown by the alarming mortality. The last week in February there were fifteen deaths, and during the past seven weeks there have been eighty-two deaths.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, MARCH 8, 1905.

TYPHUS FEVER IN LONDON.

THE recent outbreak of typhus fever in the East End of London comes as a sharp reminder that infection dies hard. So far as London is concerned, the disease in question has become so rare that a case of it has never been seen by the majority of medical practitioners of the present generation. The malady is admittedly one of the most infectious known to science, comparable only with the subtlety and virulence shown by scarlet fever and small-pox. It is therefore important to draw the attention of medical men in London and elsewhere in the United Kingdom to the fact that at any moment cases of typhus fever may come under their care in guises that may throw the unwary off their guard. Needless to say, the results of undetected and consequently exposed typhus fever may be far-reaching and disastrous. Experience shows that typhus fever, apart from a history of specific infection, is often diagnosed as pneumonia, enteric fever, delirium tremens, and other acute conditions. Mistakes of the kind, in point of fact, were committed in the early days of the present London outbreak. The fact that such errors occurred under the care of highly qualified hospital staffs shows that it is practically impossible always to detect sporadic cases of typhus fever on their first appearance in a community. The whole subject is one of vital importance, not less to the medical profession, who have reputations to save, than to the public whose lives it is the duty of sanitary science to protect. Typhus fever, at one time endemic in all parts of the United Kingdom, has for some time past been practically banished from Great Britain, although it has never lost its footing in Ireland. From time to time cases of the disease are reported in Liverpool, Edinburgh and Glasgow, as well as in other large towns in which there is a large poor population, especially when containing a number of Irish.

It is peculiarly interesting at the present time to read a well-recorded history of typhus infection in the metropolis. Such a record will be found in another part of the present issue of THE MEDICAL PRESS AND CIRCULAR (page 235). It originally appeared in the year 1899, in the form of a report presented by Dr. F. J. Waldo, as medical officer of health to the Vestry of St. George-the-Martyr, Southwark. A case of typhus fever was notified to him on February 20th, 1899, and it occurred to him that there might be a possible connection between that particular case and two previous cases in the district, the one in April and the other in October, 1898. Dr. Waldo accordingly instituted a set of painstaking and laborious investigations. The result was a brilliant vindication of the methods of modern expert sanitary science. He was enabled to trace the connection of the whole series of cases, which were linked in one long, though often tortuous and irregular chain of direct and indirect infection by exposure. The cases were treated both by private practitioners and in public hospitals. Cases and deaths were attributed to enteric fever, pneumonia, delirium tremens and other maladies. It was only at the end of several months that the death of a patient with the "mulberry" rash fully developed aroused a suspicion as to the real state of affairs, if we remember aright the circumstances made public at the time. Among the points emphasised by Dr. Waldo's report may be mentioned the following as specially worthy of notice:—First the fact that he was enabled to trace the missing links of his cases by the courtesy of the medical officers of health in neighbouring districts. Community of action between local sanitary authorities undoubtedly furnishes the key to much that is vital in the future of public health administration. It is of little use to notify and control typhus fever in, say, half a dozen London districts, if in the nearest half-dozen adjacent or overlapping districts nothing is known of the facts and the necessities of the case. So far as other points are concerned, it would be difficult to imagine a document more calculated to put medical officers more on their guard as to the pregnant possibilities of erroneous diagnosis. It has been said of the present outbreak of typhus fever in the East End that there is little danger to be apprehended from the exposure of patients suffering from the disease in hospitals and elsewhere. It is difficult to understand how any such statement could have crept into any responsible lay journal. From the scientific point of view, typhus is one of the most deadly and elusive of the pestilences that stalk by noon-day through the crowded thoroughfares of modern civilisation.

TEACHING HOSPITALS AND MEDICAL SCHOOLS.

THE report of Sir Edward Fry, Lord Welby, and the Bishop of Stepney on the financial relationship of teaching hospitals to their medical schools is bound to mark an important departure in medical education. This "committee of

three" was, it will be remembered, appointed by the Prince of Wales, as President of King Edward's Hospital Fund for London, to answer definitely the allegations made that money subscribed for the relief of the sick poor was used by certain hospital managers to subsidise medical education. The questions put to them were three in number—whether any, and if any, how much, of such money was so employed; whether any return for such contributions was received by the hospitals from the schools; and whether any hospital paying contributions in excess of actual value received from the school was justified in doing so by any special considerations. To these questions the committee replies that in 1903 University and King's College Hospitals paid no such sums to their schools; that Guy's and the Royal Free can hardly be said to have done so; but that the remaining eight of the large hospitals all contributed something to their schools. The second point is answered by saying that although the hospitals receive considerable benefits from their schools, the students, on the other hand, receive a proportionate return by being allowed to use the hospital as a "clinical laboratory," and that these mutual advantages practically balance each other. Any contribution in money from the hospital to the school, therefore, should not, in equity, be required of the hospital. Finally, they find no justification for any special excess of contribution over return. With these conclusions it will, we think, be hard to quarrel, and they contrast unfavourably with the reply put into Lord Knollys' mouth eight years ago, when Mr. Stephen Coleridge inquired of the Prince of Wales' Fund (as it then was) whether any part of that Fund would find its way into the coffers of the schools. Lord Knollys, relying on the information vouchsafed to him, answered that inquiry by saying it was not the intention of the Fund that any part of its donations was to go to the support of any medical laboratory. Medical laboratory is a difficult term to define exactly, but the clear meaning of the phrase is that no subsidy would go to the support of the purely scientific as opposed to the rigidly practical demands of the "clinical laboratory." On the face of it it must be difficult candidly to reconcile this statement and the finding of the Committee, and this inconsistency will put a powerful lever into the hands of the party whom Mr. Coleridge leads. It will be exceedingly regrettable if there is any suspicion of disingenuousness about the information supplied to the authorities of the Fund, and we hope the matter will be promptly and fully cleared up. What is clear to medical men, namely, that hospital work begins in the wards, is continued in the laboratory, and is by the necessities of the case, often completed in the *post-mortem* room—will not be clear to lay people, and donations from the hospital funds to the school funds will not be read in the light of a strict *quid pro quo*. The Committee, we think, put its finger accurately on the weak spot in the matter when it spoke of the attempt of

each of the twelve large hospitals to maintain a completely-equipped school in connection with itself. The day has long passed since a lecture theatre, a dissecting-room, and a museum supplied the essentials of a medical school. The modern school that would provide a complete medical curriculum must have laboratories on a large scale for every department of teaching, and each laboratory must be furnished with elaborate and extensive plant for its own special work. To keep up with the times the medical schools in the Metropolis have been laying out money year after year in their endeavour to supply sufficient attractions for students, and it is an open secret that several of the smaller schools are only maintained by the lecturers foregoing all remuneration, and even in some cases putting their hands in their pockets to meet deficits. This game of beggar-my-neighbour obviously must eventually involve the financially weaker brethren in bankruptcy unless the schools are relieved of some part of their burdens, and the temporary expedient of the hospital managers contributing towards the cost of the schools could only be a temporary expedient. It is characteristic of the heterogeneity of the elements composing the "hub of the Empire" that London, with its unrivalled wealth of clinical material, should remain the worst organised centre of medical instruction. The Committee rightly and properly advise that the insolvency of the medical schools shall be met, not by contributions from the hospital funds, but by the formation of a central institution with every requisite appliance where the preliminary medical subjects should be taught, and that the existing medical schools shall become places where only the last two or three years of the student's course are spent—clinical schools, that is, with the hospitals as clinical laboratories. The London University scheme to this end seems to be faring but poorly, but it is much to be hoped that it will not fall through, for in it, or in some similar arrangement, lies the only true solution of the problem.

Notes on Current Topics.

The Lincoln Typhoid Epidemic.

AT the end of last week the number of cases of enteric fever in Lincoln was over 700 and the outbreak showed no signs of abating. There has naturally been a good deal of excitement and alarm among the governing authorities of the town who have been sitting in secret conclave, and who appear to have even now formed no practical plan of dealing with the polluted drinking water which has brought this terrible disaster upon the good folk of the ancient city in question. Matters will not be mended by vacillation in the present crisis. On February 22nd, in a leading article devoted to the subject, THE MEDICAL PRESS AND CIRCULAR pointed out the only means known to sanitary science of forthwith purifying the water of Lincoln. Hitherto there has been no intimation on the part of the local journals, so far as we

have been able to ascertain, that the plan mentioned has been considered by the Council. The method is that of rapid sterilisation by the Salvator apparatus, which is known as the Vaillard-Desmaroux system in France, where it is extensively used both in civil and in military life. The Japanese, ever certain in their grasp of what is best in our Western civilisation, have no less than fifteen "Salvators" with their army in the field. It can deal cheaply, rapidly, and effectively with the water supply of any town of whatever size. As pointed out by a correspondent last week, the water supply of Lincoln could thereby be rendered safe within ten days. The Council will enormously multiply their responsibility if they neglect the repeated advice we have considered it our duty to offer.

Fine for Incorrect Diagnosis.

WE learn from the *Liverpool Journal of Commerce* that a good deal of concern is being felt by shipowners and shipmasters at the action of the stipendiary magistrate of that city in fining the master of a merchant vessel for concealing a case of plague. It would appear that the *Crewe Hall*, the ship in question, sailed from Rangoon with a clean bill of health, and as she had no illness on board, experienced no difficulty in getting *pratique* at all the ports touched at on the homeward voyage. When the colder latitudes were reached the Lascars, who composed the crew, suffered from the minor ailments which natives of warm countries experience when subjected to lower temperatures than they are accustomed to. Before arriving at Liverpool one of these Lascars had what appeared to be a feverish cold, but no significance was attached to it, and the master reported to the port officials that he had no illness on board. Now it is contended on his behalf that he meant there was no illness as touched on by the regulations, and that he himself attributed no weight to one sailor being out of sorts. The case, however, turned out to be plague; the man died, and the captain was fined £10 and costs for not answering truly the questions put to him under the twenty-third article of the Local Government Board Regulations as to cholera, yellow fever, and plague. It seems that in the book of diseases issued to the masters of ships the incubation period is given as a few days, and that, therefore, it is absurd to suppose that the captain could, in this case, have suspected plague after he had been at sea for many weeks. On the facts as stated we confess to some little sympathy for the errant skipper; if medical men were fined each time they made an incorrect diagnosis we suspect we should not hear so many lamentations over the over-crowding of the profession.

Ventilation of the House of Commons.

THE ventilation of the House of Commons has long been the subject of complaint among our legislators, and a report dealing with it has just been presented to the First Commissioner of Works. It is the result of careful work conducted by Dr.

Gordon, Dr. Huntley, and Dr. Aitken during last session. The report recommends that the air-inlet should be raised and widened—if possible without interfering with façade—and that traffic over the north inlet should cease. The moistening spray that is used to purify the air should, the investigators think, be used regularly instead of occasionally; the doors between the ventilating fan and the inlet be removed or made air-tight; traffic across the air-way prohibited while the House is sitting; pans of water or wet mats provided over the heating apparatus; and the steam-pipes be covered with asbestos. Listerian methods also are suggested to keep bacteria in check. The attendants between the air-inlet and the floor of the House are to be clothed in white linen or drill. Members are to be careful to clean their boots, and hair-matting, as being more easily sterilised, substituted for the string-matting that now covers the floors. It is recommended also that careful hygrometric, thermal, and similar observations should be kept, so that the effect of the various measures may be watched and checked. We hope that all these precautions may be beneficial to the health of our representatives, and that the inertia that they complain of as overcoming them after sitting for some hours in the House may now give way to healthy activity of the neurons. But we do not anticipate that any very satisfactory result will be arrived at, even by these elaborate measures. Fresh air is fresh air, and its stimulating and exhilarating properties cannot be obtained by any amount of moistening, heating, and filtration. Air that is fresh is fresh because it is fresh, and not because it has been treated by any artificial process. Unless, therefore, the wisdom of the Lower House can devise some means for opening the windows of the Chamber, we fear they are not likely to be able to reproduce the atmospheric delights of the Matterhorn in a confined chamber at Westminster.

A Surgeon's Visit to Thibet.

OF some interest at present, in view of the recent expedition, is the account published as long ago as 1789 by Mr. Robert Saunders, surgeon, of Boglspoor, in Bengal, of his observations during a visit to Thibet. It would seem that then, as now, the climate offered the most serious obstacle to the explorer. Among the British forces last year the greatest losses were due to frost-bite; and of the cold winds experienced by him, Mr. Saunders reported that according to native accounts exposure to them caused the loss of the front teeth—certainly an emphatic way of expressing their extreme rigour. As in many other mountainous districts, goitre was extremely common, both in Thibet and Bhutan, and Mr. Saunders makes some interesting suggestions as to its causation, giving good grounds for the repudiation of the snow-water doctrine then fashionable. Syphilis, too, was extremely common, and of a virulent type. Mercuric treatment was in everyday use, being persisted in until the patient was thoroughly salivated for ten or twelve days. The

great terror of the people was small-pox, and when a case occurred the patient was entirely isolated, often being allowed to starve. The house or village was afterwards erased, and thus a spread of the disease was rare. The surgery of the Thibetans was very crude, but their therapeutics were advanced and complex. The vegetable world supplied an infinity of drugs—mostly carminatives, aromatics, and vegetable bitters. Purgatives were imported from China, and emetics were unknown until Mr. Saunders introduced ipecacuanha.

Registrar-General's Report.

THE Registrar-General's report for 1903 is as full of interesting features as usual. The immediately striking items that arrest the attention are the continued fall in the three rates—birth, death, and marriage. To take the last first, it is not perhaps of much significance that a slight decline, .1 per 1,000, below the average of the preceding decennium should have occurred, and it is probably a reflection of a slight depression in trade, the co-relation of marriage with trade being notoriously intimate. The birth-rate continues to show the same downward tendency that has characterised it since the prosperous days of the mid-seventies, and with the arguments founded on this fall in births still fresh in our readers' minds we need not enlarge upon the meaning different parties will attach to it. The declining death-rate, however, must be a cause of unqualified satisfaction to all workers in the cause of hygiene, and we note that the rate for England and Wales, namely, 15.4 per 1,000, is the lowest yet recorded. In the last fifty years this reduction has been constant, and since 1854 there is a difference of no less than 8.1. The significance of this factor is enhanced by the coincident reduction in infant mortality and in deaths from consumption. The former shows a drop of 20 per 1,000 births from the average for 1893-1902, and the latter are but three-fifths of what they were twenty-five years ago. The zymotic death-rate as a measure of the health of a community pales before these two factors, pregnant as they are of improved conditions of living. The only infectious disease that deserves to rank with consumption as an indication of improved sanitation is enteric fever, and this disease in 1903 only accounted for 100 deaths per 1,000,000 living, as against 1,124 from pneumonia, 274 from measles, 189 from influenza, 182 from diphtheria, and 125 from scarlet fever. The whole report, if we exclude the question of birth-rate, is one of happy augury.

Researches in Leprosy.

CAPTAIN ROST, I.M.S., has been engaged during the past two or three years in researches into the bacteriology of leprosy, and has arrived at conclusions which will, if supported, cause remarkable advances in our knowledge of that disease. Though most inquirers are of opinion that the *Bacillus lepræ* which is always found in the lesions of leprosy is the causative organism, yet all at-

tempts at its cultivation have hitherto failed, and consequently the necessary proof of its connection with the disease was not complete. Captain Rost, reflecting on the well-known fact that certain organisms cannot grow in the presence of oxygen, thought that possibly the growth of other classes might be inhibited by the presence of certain other elements. On investigation, he came to the conclusion that the difficulty always experienced in the cultivation of the acid-fast organisms, to which class the *Bacillus lepræ* belongs, was due to the presence of chlorine in the culture media. By obtaining, with considerable difficulty, culture media free from chlorides, he was able to grow tubercle, leprosy, and the other acid-fast bacilli with ease. The *Bacillus lepræ* forms in fluid media a thick deposit, which, on shaking, appears as a curly, white, stringy fluff. On solid media it forms a growth like that of the tubercle bacillus, but turning yellow or red. These results are in themselves of prime importance, but Captain Rost claims to have gone further. Having kept the cultures growing for six weeks, he carefully filtered them, reduced the bulk of the fluid, and used it as an injection in the treatment of leprosy. He claims that one or two injections are sufficient to restore sensation to the anæsthetic patches, and that a more prolonged treatment causes alleviation of pain, resolution of the nodules, and healing of the ulcers. In no case has injection failed to produce improvement. We understand that Captain Rost's serum is at present under trial by many hands in different parts of India, so that we are likely to hear further of it in the near future. Until the reports of these investigators, both clinical and experimental, are made known, one cannot express any opinion as to the true value of Captain Rost's investigations.

Treatment of Consumption in Ireland.

THE history of the Royal National Hospital for Consumption for Ireland, though short, has been one of uninterrupted progress. It is nine years within a few days since a hospital for consumption, with twenty-four beds, was opened by the Marchioness of Zetland, near Newcastle, in one of the prettiest parts of the County Wicklow. To-day it stands fully equipped with one hundred beds, thereby completing the original scheme of the promoters. The Board of Governors has wisely decided not to attempt, at any rate for the present, any further extension on the present lines, but rather to devote themselves, if they are at liberty to extend their work in any direction, to widening the scope of the institution. In particular, the need is felt, as was pointed out eighteen months ago by our Commissioner, of an out-patient department in the City of Dublin where past patients might attend for advice and treatment. One of the chief difficulties sanatorium treatment has to contend with is that of maintaining a hygienic mode of life once the patient has returned to his ordinary surroundings. The number of patients treated in 1904 was 372, that in the previous year being 329; we are glad to notice that the governors

are therefore availing themselves of their increased accommodation rather by giving each patient a longer stay in the hospital than by largely increasing the number treated. We have always held that it is wiser to succeed in producing a permanent improvement in a comparatively small number of patients than to cause slight but temporary improvement in a larger number. The statistics of the Newcastle Hospital are of more than ordinary value, as their compilation since the opening of the hospital has been in the hands of the same resident physician, Dr. Steede; they have thus a greater uniformity than those of many public sanatoria.

John Hunter.

ALTHOUGH Mr. Tweedy, in his Hunterian Oration, wisely made no attempt to add any new facts to our knowledge of the life of the great surgeon, yet by his broad and philosophic appreciation he has given us a better grasp of his mind and work. When Mr. Tweedy remarks that "the greatest men are estimated by the influence they exert upon the thoughts and activities of those who follow them," he claims for Hunter a place among the very greatest, for to him, more than to any one other man, is due the founding of medicine and surgery on a true basis of science. It is not to be understood that there were no scientific surgeons before Hunter, but there is none who stands forth in the same way as the father of modern surgical science. The collection of the magnificent museum which bears his name is perhaps the least of his works, though that alone would be sufficient to place him among the immortals. His great merit was his method, or, to put it subjectively, his mental attitude. He constantly sought for principles, and never remained content with mere facts. On the other hand, he did not proceed, by Baconian rule of thumb, from facts to *axiomata minora*, and thence through *axiomata media* to *axiomata generalissima*, for as Mr. Tweedy rightly points out, no discovery ever was, or ever can be made by strict Baconian methods. Hunter, like all the great men, made discoveries, as it has been called, "by chance," but it is only to the great men such chances occur. In other words, he proceeded by hypothesis, and his greatness is no less shown by his rigid restraint in the testing and rejection of unsatisfactory hypotheses than by his fertile ingenuity in inventing them. To a student who drew attention to some expression of opinion at variance with his previous teaching, he replied, "I hope I grow wiser every year. Never ask me what I have said, or what I have written; but if you will ask me what my present opinions are I will tell you."

Medical Practice in Siberia.

IF it were for nothing but its vastness, Siberia has for most minds a curious fascination. Recent events have, moreover, given it an additional interest which renders all the more attractive anything that helps to bring home to us the life of its people. Dr. Hassim, now of Chicago, but formerly for some years a practitioner of the dis-

trict of Yenesseysk, contributes to a recent number of the *Journal of the American Medical Association* a description of the conditions of medical practice in Siberia, which gives us an appalling picture of the lack of medical attention from which the people suffer. The towns, it is true, are well supplied with medical men; in Krasnayarsk, for instance, to a population of 30,000, there were twenty-four medical men, and in Yenesseysk, to a population of 10,000, there were seven. Many of these are in Government employ for special duty, and do not undertake private practice. The towns, however, are small and far apart, and the intervening country is practically devoid of medical attention in sickness. The province of Yenesseysk, which contains about 1,000,000 square miles, was, until a few years ago, divided into six districts, to each of which two medical men were allotted, one of whom, however, performed only medico-legal duties. These physicians lived altogether in the towns, and only visited the country parts of their districts once a year, and occasionally during epidemics. Even in the latter case they did little more than travel from one village to another and record the number of sick. Dr. Hassim had himself to travel eight hundred miles during a bad epidemic of typhoid fever, but rarely was able to spend more than an hour or two in each village. The very unhygienic conditions under which the peasants live are responsible for an unhealthy condition of the population with which obviously there is no attempt to cope.

Varicocele Among Recruits.

AMONG the various minor ailments which are the bane of male adolescence, varicocele is by no means the least important. The aching pain to which it gives rise when fully developed is quite sufficient to prevent the sufferer therefrom from taking part in any occupation involving much standing, walking, or other physical exertion. Teachers of surgical anatomy are always most careful to impress upon students the fact that the condition is more common upon the left side, owing to the mode in which the left spermatic veins empty themselves into the renal vein upon the same side. To army surgeons varicocele is of considerable interest, owing to the disability which it causes among soldiers. As a matter of fact, the rejection-rate among recruits is fourteen per thousand from this cause alone, while 2½ per cent. are supposed to be suffering from this affection in more or less degree. The success which has attended Bennett's operation for the radical cure of varicocele has enabled many men to lead useful lives who would otherwise have been wholly incapacitated from active service. Major S. G. Allen finds that in 1903 the number of cases of varicocele operated upon in the Royal Herbert Hospital, Woolwich, was second only to that undertaken for the radical cure of hernia, it being understood, of course, that only bad cases of the disease are admitted. Minor degrees of the affection must be far more frequent, and of these no series of statistics are

forthcoming. The fatigue and physical exhaustion attendant upon forced marches would be felt to a greater extent by a man who has but a slight varicocele than by the individual whose pampiniform plexus is normal.

Water-Drinking in Typhoid Fever.

It is difficult to resist the impression that febrile states demand a more copious flushing, as it were, of the excretory channels than normally takes place. A feverish patient instinctively craves for an abundance of cooling liquid, and no matter whether this be merely water or some form of fluid nourishment, it is eagerly swallowed. This desire for drinking is frequently more obvious in the case of young children. Nevertheless, there is often an indisposition manifested on the part of medical practitioners to order, and nurses to give, "drinks" whenever the patient asks for them, on the ground that the digestion may be disturbed. For this there is, perhaps, some excuse. In the case of typhoid fever, several trial experiments have been recently undertaken with the view of ascertaining if the excretion of urine is proportional to the amount of fluid ingested; in other words, if the kidneys retain their power of eliminating water in this disease. Dr. Edward F. Cushing, of Cleveland, Ohio, administered four ounces of pure water to a series of typhoid patients every fifteen minutes during the waking hours throughout the course of the fever. It was found that a large quantity of water could be borne without any discomfort by the patients, and also that an abundant flow of urine was secured. Just at first there was a little resentment displayed by a few, but these soon came to like the water. Other observers have conducted similar experiments, and all are agreed that patients are much more comfortable under the treatment, and that the nervous symptoms are greatly lessened. It would, therefore, seem as if we have here an additional means of combating the toxæmia of the disease, and the results certainly show that the eliminating capacity of the kidneys is little, if at all, impaired in enteric fever.

Certification of Deaths.

How long, one wonders, will it be before the present unsatisfactory and scandalous condition of the law and administration of this country with regard to death-certification is brought into line with the requirements of a civilised country? It is difficult to speak with patience of the confused practice that obtains at present. A medical man is bound under penalty to give a certificate of death to the relatives of a patient unless he can find a "reasonable excuse," and although the certificate is given without fee or reward, he may find the authorities at Somerset House wanting further information from him. On the other hand, any quack, pretender, or ignorant person may give a certificate which the local registrar—often a person of very little education—is willing to accept, and even no certificate at all may be given, and the body buried without the cause of death

being registered. At an inquest held at Southport the other day on the body of a woman, aged forty, it came out that she had been attended in her illness by a person calling himself a herbalist. This erudite individual had been treating the unfortunate subject of his ministrations with raspberry leaves, concoctions of slippery elm, and "reanimating drops." Whatever effect the first two of these remedies may have had, the "reanimating drops" were succeeded by a process of examination on the part of the patient, and as no medical man was called in, the herbalist gave a certificate saying that death was due to paralysis followed by epilepsy. Fortunately, the registrar had sufficient sense to refuse the certificate, and an inquest was ordered. The Coroner made some forcible remarks about the impropriety of the whole proceedings, saying that "a joiner, a bricklayer, or a collier might as well issue a certificate as a medical herbalist." The jury returned the verdict of "death from natural causes," and added the naive rider that the herbalist was "unwise" in issuing the certificate. It is difficult to see where the unwisdom came in; the man knew that the only way to avoid an inquest was to give a certificate, and that this was not unlikely to be accepted. The people who are "unwise" are those who allow their civic organisation to contain such a loophole for imposture and crime.

Sea Sickness or Altitude Sickness.

ALTHOUGH the success that attended the recent attempt of the bold aeronauts to travel in balloon from London to Paris cannot be said to bring that mode of locomotion within measurable distance of becoming an alternative to the usual route, it brings us face to face with its possibility. Whether, should it come to pass, travellers who at present endure the agonies of sea-sickness would gain thereby is another question. The emotions from which our parents suffered when first they ventured on a journey by train were as nothing to those that will await the pioneers in aerial navigation. The traditional "now we're off," after a parting kiss several times repeated, will be followed by a masterly swoop into the sky associated with a visceral constriction compared to which the flightiest lift, nay, even an ascension from the depths of a coal-mine, is but child's play. As far as one can judge, the accommodation available on the aerial vessel is not likely to allow of the distribution of travellers into social categories, so that a hideous promiscuity will be unavoidable. But sea sickness; shall we at last have exorcised this bogey by quitting the agitated surface of the waters for the more stable environment of the ambient air? The chances are that in evading sea sickness, which is one of "the ills we have," we shall be "flying to those we know not of." But, as a matter of fact, we do know something of "mountain sickness," and our information concerning it has been confirmed and added to by the published narratives of our soldiers in the recent expedition

to Thibet. Many of them suffered horribly from prostration with nausea and oppression when they reached the higher altitudes; indeed, their state was fully as bad as that of the sea-sick person who has reached the stage at which he "fears" that the ship may after all weather the storm. On the whole we are disposed to congratulate ourselves that air trips from London to Paris are unlikely to become fashionable within the near future; and if called upon to make our choice of the lesser of the two evils, we should prefer to take part in a motor-car accident to one the scene of which is laid in or near a balloon.

Modern Prescriptions.

THE present age is characterised, among other things, by the decay of the prescription. Some of the senior members of the profession regard this as a regrettable sign, whilst many of the younger ones snort "polypharmacy," take their pen, and write quickly "Jones' hypophosphites" or "Robinson's corpusculogen," without compunction or concealment. The art of prescription-writing in this country is certainly on the decline, but, on the other hand, the art of pharmacy is certainly rapidly improving, and it is quite open to debate whether the patient is not as well off with a well-found, carefully-blended preparation as with the quondam "blunderbuss" mixture. In the *Proceedings* of the Philadelphia County Medical Society for January of this year is a paper by Dr. M. C. Thrush, who took the trouble to inspect the prescription-files of two of the leading chemists in Philadelphia, running through five hundred consecutive prescriptions from each. In these prescriptions there were thirteen instances of chemical and pharmaceutical incompatibility, but only one of therapeutical incompatibility. Fifty prescriptions—all by old-fashioned physicians—contained six or more ingredients; seven hundred and eighteen, two to five ingredients; four hundred and eighty-four (less than half) contained official preparations only; three hundred and fifty-nine proprietary preparations, in whole or in part, and two, patent medicines. One of the latter, however, it is fair to state, was written by an osteopath. Dr. Thrush's conclusions were that the most able physicians employ the fewest drugs, and the best-educated prescribe only official preparations. The younger men generally showed marked want of knowledge in the art of prescribing, and it is sad to have to add that only 621 prescriptions were correctly written. These remarks of Dr. Thrush's are particularly interesting as showing the same tendencies in America as in this country. Our own conclusion would be that the medical curriculum is too full nowadays to allow of a full and accurate training in the art of prescribing.

PERSONAL.

THE KING, on the recommendation of the Home Secretary, has been pleased to appoint Dr. James Craufurd Dunlop, to be an additional member of the Royal Commission on the care and control of defective and feeble-minded persons.

THERE has been presented to the Dartmouth Cottage Hospital an excellent painting of the late Mr. Arthur Kyffin Crossfield, L.R.C.P., L.R.C.S. Edin., by the committee of that institution in memory of the valuable services which he rendered to the hospital as one of the honorary medical officers.

ON February 21st, in Convocation, the University of Oxford formally accepted the offer of Mr. Alfred Beit to found a professorship, lectureships, and a prize for an essay in Colonial history, and expressed their gratitude to Mr. Beit for his offer.

THE honorary Fellowship of the Royal College of Surgeons in Ireland was formally conferred on Anthony Traill, the Provost of Trinity College, on February 25th, when he signed the roll as an honorary Fellow of the College.

LIEUTENANT-COLONEL H. K. MCKAY, C.I.E. (Bengal) has been appointed Inspector-General of Civil Hospitals and Sanitary Commissioner Burmah, vice Lieutenant-Colonel S. Little. Major C. H. Bedford is posted to the Finance Department.

LIEUTENANT-COLONEL ALFRED F. S. CLARKE, R.A.M.C., on his leaving Sandhurst after twenty-two years' service as surgeon of the College, has been presented with a silver salver with suitable inscription and an opal and diamond ring for Mrs. Clarke, by the officers of the Royal Military College, past and present.

A PRESENTATION of a testimonial was made to Dr. W. W. Ireland at the Royal College of Physicians of Edinburgh last week, on the occasion of the fiftieth anniversary of his medical graduation.

DR. SYKES, medical officer of health for St. Pancras, has prepared a report on the subject of the large infantile mortality, and the Borough Council have requested him to elaborate a scheme.

A DISCUSSION upon the causes of the increased prevalence of anthrax in Great Britain will be opened by Professor Sheridan Delépine, at a meeting of the Incorporated Society of Medical Officers of Health to be held at 9, Adelphi Terrace, Strand, London, on March 10th, at 7.30 p.m. The chair will be taken by the president of the society, Dr. J. F. J. Sykes.

THE post of honorary surgeon to the Metropolitan Fire Brigade Widows' and Orphans' and General Benefit Fund rendered vacant by the death of Mr. Herbert Allingham has been accepted by Sir A. Fripp.

DR. W. M. HICKS, F.R.S., Principal of Sheffield University College, has been appointed one of the Vice-Presidents of the Mathematical and Physical Science section of the British Association; and Professor Arnold, also of University College, has been appointed a special lecturer.

FURTHER investigations, under the auspices of the Royal Society's Committee, into the causation of sleeping sickness in the Uganda Protectorate, will be undertaken by Professor E. A. Minchin, Jodrell Professor of Zoology in University College, London.

AMONG the list of those elected this year to the Royal Society are Dr. J. G. Adami, Professor of Pathology in McGill University, Montreal; Mr. E. W. MacBride Professor of Zoology in the same University; Dr. F. G. Hopkins, Reader in Chemical Physiology at Cambridge University, and Lieutenant-Colonel D. Prain, I.M.S.

M. ANDRE LEFEVRE has bequeathed £30,000 to the School of Anthropology, Paris, also his head.

PROFESSOR JOHN EDWARD SHORROCK MOORE, A.R.C.S., F.L.S., has been appointed Director of the Cancer Research, Professor Moore is at present acting

as Professor of Natural History in the London Royal College of Science and is well known as an investigator in cancer, having been associated in the work with Messrs. Farmer and Walker.

DR. W. J. BRUCE and Dr. H. R. Ellis have been appointed Medical Officers of the Colony of Lagos. Dr. Ellis has been attached to the Lagos Hospital and appointed for duty connected with the General Medical and Sanitary Work of Lagos Town. Dr. Bruce is at Ibadan with the Oshogbo Railway Service Medical Branch.

DR. MACNAUGHTON-JONES, Master of Obstetrics (*hon. causa.*) Royal University of Ireland, formerly University Professor of Midwifery in the Queen's University, has been elected Honorary Member of the Obstetrical Society of Leipzig.

To perpetuate the memory of the late Sir William Banks, M.D., L.R.C.P., of Liverpool, a subscription has been opened in that city, and so far has reached a total of £5,000.

MR. THOMAS HAYES has been elected to the office of clerk to St. Bartholomew's Hospital. Mr. Hayes has held the secretaryship of the East London Hospital for Children for many years.

MR. W. JOHNSON SMITH, F.R.C.S., principal medical officer of the Seamen's Hospital Society, Greenwich, after being a member of the surgical staff of that hospital for thirty-five years, is about to retire. In recognition of his public service, the medical staff of the Seamen's Hospital Society propose to entertain him at dinner, and present him with a testimonial, on Wednesday, April 5th, at the Trocadero Restaurant, Sir Patrick Manson will take the chair.

MR. CANNY RYALL, F.R.C.S.I., has been appointed Surgeon to the Queen's Jubilee Hospital, London.

H.R.H. THE DUCHESS OF ALBANY, President of the Ladies Association, accompanied by H.R.H. Princess Alexander of Teck, Princess d'Erbach, His Grace the Archbishop of Canterbury, and others, honoured the Royal Waterloo Hospital for Women and Children with a visit last week.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

EDINBURGH.

ROYAL EDINBURGH ASYLUM: DR. CLOUSTON'S ANNUAL REPORT.—After giving the usual statistics for 1904 (a record year as to the total number of patients under treatment), Dr. Clouston alluded with satisfaction to the relief which the removal of 185 rate paid patients to Bangour Asylum had given to their wards, and to the increase in admissions of private patients rendered possible thereby. As the accommodation at Bangour consisted as yet only of large wards suitable cases had to be selected for sending there, and this had left a disproportionate number of weak, noisy, suicidal, epileptic, and paralysed patients in Morningside, so that scarcely any reduction of the nursing staff had been possible, and the expense of treatment had gone up. Twelve voluntary patients were received. The recovery rate among these was higher than among certified cases—65 per cent. last year and 50 per cent. over the past ten years. Having emphasized the need for prompt and early treatment of incipient mental disorder, Dr. Clouston observed that in the Scottish Acts there was concealed in the middle of a section for another purpose a vague provision for the treatment of any patient for six months with a view to cure if a doctor wrote a certificate to that effect. A very slight expansion and definition of this little-known and seldom acted on provision would enable public hospitals or local authorities to

set up psychiatric wards in a strictly legal manner. Mental disease should not be looked on as an isolated fact in the life history of mankind, but as one of a vast series of consequences of ignorantly or wilfully breaking the laws of healthful living. If a tenth of the thought and a twentieth of the effort at present expended on political discussion and unhealthy amusement were for a few generations given to health knowledge and disease prevention, men and women would soon recognise their health risks and duties. To see an Education Bill that made no provision for teaching health, an educational system that neglected the formation of self-control and character, was a vivid proof of the present fatuous state of mind in regard to this tremendous problem. Of the cause of insanity during the year, excessive drinking stood out first. As his previous statistics and conclusions had been much criticised, he had this year taken more than usual care to obtain correct histories, and had given the benefit of the doubt to all as to whom any doubt existed. In 19 per cent. of his cases alcoholism was the undoubted cause of the upset of the brain functions; this was 10 per cent. less than in 1903, probably correlated to the past year of dull trade. Alcoholic insanity, in the scientific sense, formed 15 per cent. of the admissions. His proportion of female alcoholics was steadily rising, and last year the total number actually exceeded that of the males. The admissions of general paralytics were down this year, but there was this peculiar feature that an unprecedented proportion—22 out of 49—occurred in women. This increase of general paralysis in modern times, especially among women of the uneducated classes, meant that the lives of some sections of urban populations were more immoral than formerly. The bodily condition of the patients admitted was very poor. Of the discharges last year 150 were recovered (32·8 per cent., or 9 below the average) and 177 relieved. The death-rate was higher than ever before—14·6 per cent. on the average, and 9 per cent. on the total number under treatment. The high death-rate was, in part, accounted for by the number of patients who died within a fortnight of admission, and the growing tendency among the poorer classes to send troublesome and senile "wrecks" to the asylum to die.

EDINBURGH ROYAL INFIRMARY AND HOSPITAL ADMINISTRATION.—Last week the managers had under consideration a communication from the British Medical Association inviting representatives to a conference in London bearing on hospital administration, with a view of remedying abuses. The resolutions which were to be discussed at this conference will probably appear in another column, and need not be repeated here. By a majority it was decided not to send a representative on the ground that certain of the resolutions to be considered—viz., that inability to pay for medical treatment be the consideration for admission, that no charge be made for treatment, that subscribers' letters shall cease, and that there be an age limit for the staff—were already in force in the infirmary, and that the others were outside the Charter. It seems to us that as a matter of courtesy, if for no other reason, the managers would have done well to have sent a representative to this conference, on the footing, of course, that their action in doing so bound them in no respect. In the action they took, however they were no doubt to a great extent justified by the peculiar position which the infirmary holds as a national, not merely a metropolitan charity, a position of which its pride is expressed in its motto, "Patet omnibus." And again, while it would be ridiculous to assert that its offices are never abused, it is doubtful whether any system of inquisition into the circumstances of those seeking advice (and practically this must form a fundamental part of any system for checking the undeserving applicant) would not do more harm by checking the attendance of the deserving poor than good by driving away the sturdy beggar; for the general opinion of medical men, both on the staff or outside of it, is that on the whole the institution is seldom used by those for whom it is not intended,

The medical representatives on the board were apparently divided as to the propriety of sending a delegate to London, as the mover of the motion which was carried and the mover and seconder of the amendment that the invitation be accepted were medical men.

GLASGOW.

HEALTH EXPERTS AND THE MEDICAL PROFESSION.—For several weeks a widely circulated religious paper called *The British Weekly* has had a page or part of a page of letterpress devoted to "England's Greatest Health Expert," who is no less a personage than Mr. Eustace Miles, M.A.—mark the degree—and to Mr. Eugen Sandow, late Music Hall Artiste, and generally billed as the "strong man," who has had an entire page to himself, with an illustration showing him addressing what is called a representative gathering of medical men. Parenthetically, we may say that this gentleman's portrait appears in one of the monthly magazines along with those of Harvey, Koch, Jenner, Pasteur, and Virchow, in an article with the heading "Great Healers of Mankind." The last week's issue of this enlightened publication, *The British Weekly* devotes considerable space in large type to "The last chance. Only twelve days more. The great *British Weekly* offer is now closing. Only a few days more will Mr. E. Miles be able to give the *British Weekly* readers the Miles Individual Health Course at the greatly reduced fee of £1 11s. 6d." Again, we are told that thousands of grateful patients throughout the country testify to Mr. Miles' success in their own individual cases. With reference to Mr. E. Sandow we read that "the greatest living specialist in dealing with nervous breakdown of the nervous system is Eugen Sandow. There is scarcely an ailment which has not yielded to his judicious treatment—chronic constipation, indigestion, loss of vigour, insomnia, and nerve troubles in general have all been cured permanently; while such scourges as asthma, incipient consumption, curvature of the spine, and general deformities have been fought and conquered." Let it be noted that Messrs. Miles and Sandow are referred to in this paper in a way that would indicate that the letterpress is not in the form of advertisement. If "Health Experts" can accomplish so much and prove themselves "Great Healers of Mankind" without passing through the usual portals of our Universities and colleges, for a five years' costly medical training, then why should we trouble sending our sons to such institutions to be carefully educated and trained in the various branches of preventive medicine, as well as giving the public the assurance of being skilled to treat disease in its numerous and complex forms by receiving degrees or qualifications to practise? We may just say that we are much surprised to find the names of several members of the medical profession appearing in connection with Mr. Sandow's flattering eulogies in the press. The subject has assumed such serious dimensions that we shall venture to refer to it again at no very distant date.

Correspondence.

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

THE TREATMENT OF INOPERABLE CANCER.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I have to thank you for your kind review, published in your last issue, of my pamphlet, "Some Methods of Hypodermic Medication in the Treatment of Inoperable Cancer," and in reference thereto I should be glad of your permission briefly to add some further conclusions which have recently suggested themselves to me.

I may remind the readers of my pamphlet that I therein raised the question between the possible connection between diabetes and cancer. This line of inquiry opened up the whole question of the glyco-genic function of the liver. The significance of this becomes at once apparent in view of (1) the excess of glycogen in foetal tissues, and (2) the known excess of glycogen in malignant growths. Bearing on these

points the factors which present themselves are these: Is there, in this reversion to glycogenic tissue and cell growth, (i) an over-production, or (ii) a non-conversion of glycogen, either locally or dependent generally on some nutritional disturbance of the liver or pancreas? Obviously in either case the point to be determined is the use of some means by which the excess of glycogen may be reduced. Many experiments subsequently undertaken with various ferments led to the discovery that the proteolytic ferment of the pancreas most effectually broke up glycogen, and led me to begin trial of hypodermic injections of trypsin.

Meanwhile, I have been gratified to learn that Dr. J. Beard, of Edinburgh, whose conclusions have been arrived at from embryological research, independently and amply confirms the view that the pancreas is at fault. He, while holding the view that the existence of an antithesis of enzymes is at the basis of cancer, and on the one hand an acid intracellular enzyme present; on the other, while alluding to the presence of traces of trypsin in normal tissues, significantly notes its absence in malignant tumours and the probable connection between this and their development. (a)

I am, Sir, yours truly,

JOHN A. SHAW-MACKENZIE.

42 Green Street, Park Lane, W.,
March 3rd, 1905.

THE LINCOLN TYPHOID EPIDEMIC.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The letter of "Viator," in your issue of March 1st, has a quality lacking in the vast majority of correspondents' letters, inasmuch as it offers solid comfort and advice instead of the familiar cold douche of criticism. It so happens that my attention was drawn some time ago to a French pamphlet describing the "Salvator," or Vaillard-Desmaroux, apparatus for sterilising water. So far as one could judge from that description, the apparatus seemed to be a model of ingenuity, simplicity and efficiency. Its practical value is evident from the fact that it has been widely adopted in France, especially by the military authorities. The Japanese, too, are at the present moment using the apparatus extensively for supplying their troops in Manchuria with pure water. In addition to the testimony of many distinguished French scientists, we have that of Dr. Thresh, the well-known English authority on water, who speaks highly of the merits of the Salvator.

The apparatus, however, has not yet become known generally to sanitary and engineering experts in this country, or the foregoing remarks would be superfluous. At the present moment the existence of a means of rapidly and effectively sterilising the water-supply of a town cannot be too widely known. "Viator" tells us that the apparatus could be brought over and set up within a week. The expense of such an installation would be comparatively small, and, in any case, a consideration of that kind should not be allowed for a moment to weigh in the balance against the chance of suffering and death imposed upon thousands of Lincolnians.

The question the country will want answered is, "What is Lincoln doing to cope with the present terrible disaster?" If it be subsequently shown that an apparatus exists capable of instantaneously converting a specifically polluted into a bacteriologically pure water supply, and if that safeguard be deliberately disregarded by the local authorities of Lincoln, one would not greatly care to occupy the position of any Councillor responsible for the maintenance of the present *non possumus* opportunism.

Science is science, and nowadays exact proof could be obtained within a few hours of the truth or other-

(a) "The Cancer Problem." By J. Beard, D.Sc., University Lecturer in Comparative Embryology, Edinburgh; *Lancet*, February 4th, 1905. "The Cancer Problem and Cancer Research." J. Beard, D.Sc., and John A. Shaw-Mackenzie, M.D., Lond.; *Lancet*, February 11th, 1905 (Correspondence).

wise of the claims of the Salvator apparatus to scientific confidence. Has Lincoln made that inquiry?

I am, Sir, yours truly,

DAVID WALSH, M.D.

Hanover Street, London, W.

THE VALUE OF LIGHT IN OUR DAILY LIFE. To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In reading the clear and simple summary of our knowledge of the value of light in our daily life, by Mr. Tucker, it is natural for a doctor to see with satisfaction that the Architect—*vide* the *Public Health Engineer*—is taking an interest in the subject, and that the scientific principles connected with it are likely to be studied by those engaged in the important work of architecture in its widest sense. There is no doubt that our Architects will have to study the questions of how best to heat and light our buildings, and that they must not remain in ignorance of the science which bears upon these important questions. How best to light and warm our houses are questions that require most serious attention, and at present they are questions that both chemists and architects find difficult to deal with, as they require special knowledge and study. Architects have not studied the questions of heating and lighting houses, and chemists generally consider these matters as belonging to architecture and not to chemistry. It is quite clear that a knowledge of how we ought to heat and light our houses is absolutely necessary to those who are engaged in architecture, and the subject is one which comes under the head of public health, in a very marked way.

I am, Sir, yours truly,

R. L.

THE LEGALITY OF BOGUS MEDICAL AND DENTAL COMPANIES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR

SIR,—I am compelled to take exception to a remark at the conclusion of your otherwise admirable article on the "Legality of Companies Formed for Medical and Dental Practice." You say "... whether the alleged cures are effected by electricity, magnetism, hypnosis, or humbug."

The association of electricity with humbug in your article is at least unfortunate, and on behalf of those who like myself, devote their whole time to electro-therapeutic work and believe in its possibilities, I must protest strongly against the implied suggestion.

The attitude of the Profession in the past has surely been hostile enough to the science of electro-therapeutics and those who practise it, without receiving encouragement from an important medical journal.

I am, Sir, yours truly,

RICHARD J. COWEN, L.R.C.P., L.R.C.S.
15 Half Moon Street, Mayfair, W.,

March 2nd, 1905.

[Our comments referred to practice by bogus companies, and had no reference to the use of electricity by properly qualified medical men. The position of electro-therapeutics in medicine is too clearly established to need defence, or to fear attack.—ED.]

International Association of the Medical Press.

THE conference of delegates of the International Medical Press Association will be held this year at Berne on April 27th and following days, under the presidency of Professor Cortezo, of Madrid.

Hygiene and Temperance.

A MEDICAL conference on the teaching of hygiene and temperance is to be held at the Examination Hall, Victoria Embankment, on Friday, March 24th, at 5 p.m., Sir William Broadbent presiding. Sir Victor Horsley is to speak on the present position of the scheme for education in hygiene and temperance; Sir Thomas Barlow on the present position of the medical profession in relation to alcohol; and Mr. W. McAdam Eccles, M.S., on the teaching in medical schools of the pharmacological and toxic properties of alcohol.

Special Articles.

SURGEON-GENERAL EVATT'S REPORT TO THE IRISH MEDICAL ASSOCIATION.

THE Council of the Irish Medical Association at its last meeting had again under consideration the unfortunate report on things in general which was presented to it by Surgeon-General Evatt, and to which we have had occasion to refer in terms of strong disapproval in our recent issues. The most important question, as we understand, which came before the Council was whether the report was to be circulated or not. To have accepted it would have meant not only the loss of the friendship and good wishes of the leaders of medicine in Ireland, and the sympathy and active assistance of the Irish Colleges, but would also have meant the resignation *in globo* of the Committee of Council. The meeting was, we regret to learn, a stormy one, but wise councils prevailed and the following resolution was adopted:—"That Surgeon-General Evatt's report be not published or circulated to members, and that the committee already appointed consider what portions of the report be adopted. We also, with no uncertain voice, disassociate from our programme all the offensive statements in the report which refer to the Royal Colleges of Surgeons and Physicians, and the members of the profession generally." We congratulate the Association on having passed successfully through a period of much difficulty, and on having successfully weathered the storms created by Surgeon-General Evatt's ferocious blasts. It was not to be expected that, during the passage, cross-currents could be entirely escaped, but they proved too insignificant to influence the course of the ship, and the rocks that would have torn the bottom out of the Association were escaped. The Irish Medical Association is a necessity to the welfare of the profession in Ireland, but it must be reorganised. It this is done in a thorough and permanent manner, we look forward to a future not such as that so vividly imagined by the learned and gallant general, but to one in which a representative body, harmoniously working will unify the medical profession and will raise it to the position which it should occupy in the councils of the land. We propose returning to this subject in our next issue.

Obituary.

JOSEPH HENRY HARRIS LAWRENCE, M.R.C.S. ENG.

THE news has come of the death of Mr. J. Harris Lawrence, for many years a practitioner in Widcombe where his father and brother were in practice before him. Mr. Lawrence left his native city last year, and few knew whither he had gone until news of his death under painful circumstances arrived from Australia. He was a well-known figure in Bath. Much sympathy will be felt for his widow and family who still reside in Bath.

RICHARD NOWELL HALLIWELL, M.R.C.S. ENG.

Mr. Halliwell, who, since his retirement seven or eight years ago, lived at Abbey Road, Llandudno, died last week at the age of 75, and is survived by two sons and a daughter.

CHARLES BROWNE, F.R.C.P. ED., M.R.C.S. ENG.

It is with great regret we record the sudden death of Dr. Charles Browne, at the age of 72, from heart failure, on February 21st. Charles Browne was specially known to, and valued by St. Thomas's and Guy's men; and in his earlier associations was a marked professional figure in South London. He was the son of Dr. Tobias Browne, a well known South London practitioner, and represented the third generation in the same practice; it was only in later years, when, wishing for more leisure, that he went to consulting rooms in Moorgate Street. For many years joint physician to the Equitable (London) Insurance Society,

he had had a lifelong connection with the Apothecaries' Society, of which his father was Master in 1865, and himself in 1901. Up to the time of his death he was still acting as the Society's visitor at the professional examinations held in their Hall. He was educated at Guy's, and took the L.S.A. in 1854, the M.R.C.S. Eng. 1855, and the F.R.C.P. Ed., in 1881.

PROFESSOR ADOLF BASTIAN.

PROFESSOR Adolf Bastian, director of the Berlin Ethnographical Museum, has died at Port of Spain, Trinidad, in his 79th year, while on a scientific expedition. He was for many years a distinguished traveller and had a wide reputation as the author of numerous ethnological and anthropological works, of which the best known is "The Peoples of Eastern Asia."

EDWARD ATKINSON, M.R.C.S. ENG., L.S.A.

MEDICAL and other professional men in Leeds must deeply regret the death of Mr. Edward Atkinson, surgeon, which took place on March 1st, at Harrogate. Mr. Atkinson became a member of the Royal College of Surgeons, England, in 1852, and after filling the post of house surgeon at King's College, he went out to the Crimea. He was attached to the hospital at Scutari, the scene of Florence Nightingale's devotion, afterwards travelling to Jerusalem to take up the position of surgeon at the English and Prussian Deaconesses' Hospital. He stayed there till 1860, and in his four years' work was associated with Dr. McGowan. On his return to England he settled in Leeds, but many years ago gave up private practice, and became solely a consulting surgeon. A short time since he gave up his consulting work, and went to reside at Harrogate. A love and knowledge of natural history had been fostered and increased by his residence in the East, and he was known as a clever speaker in the branches of science in which he was specially interested. He was a Fellow of the Linnean Society, and honorary curator in zoology at the Museum of the Leeds Philosophical and Literary Society. He had also filled the presidency of that body. In private life he was the most genial of men, and his company and friendship were greatly esteemed. Mr. Atkinson, who died at the age of 75, leaves a widow and several sons, the eldest of whom is Dr. F. E. Atkinson, medical officer of Health for Settle.

WILLIAM WHITE GEORGE, M.B., C.B. GLAS.

DR. William White George, son of the Rev. James George, of Dundee, died last week at Dunrossness, N.B. The deceased, who was only thirty years of age, received his early education at Dundee High School, and latterly at the University College. After taking his medical degree at Glasgow University, Dr. George was appointed medical officer of health to the Parish of Dunrossness, in Shetland, where he carried on an extensive private practice, extending over an area of about twenty miles. His genial temperament won for him great popularity. He had been married only eight months.

LADY LAKING.

LADY LAKING, wife of Sir Francis Laking, one of the King's Physicians in Ordinary, died last week at her residence, in Pall Mall, at the age of 62. Lady Laking was the daughter of Mr. Joseph Mansell, of Kensington, and was married to Sir Francis Laking in 1875. She leaves an only son, Mr. Guy Laking, keeper of the King's Armoury.

Laboratory Notes.

PLASMON OATS.

IN this preparation (International Plasmon Co., Ltd.) the best Scotch oats are treated in such a way that the husk and fibre are entirely removed and the oatmeal thus prepared is blended with Plasmon; a most valuable food is thus obtained—rich in nitrogenous principles and free from substances which might cause irritation. Our analysis has shown the following

results:—Water, 11.06 per cent.; ash, 2.15 per cent.; cold water extract, 9.30 per cent.; nitrogen, 3.25 per cent.; albuminoids, 20.60 per cent.

The water and ash are lower than in ordinary oatmeal, while the cold water extract and albuminoids are considerably increased, thus affording evidence of the nourishing and sustaining properties of this preparation. Plasmon oats only require four minutes boiling and when prepared resemble a fine oatmeal in taste.

ALLENBURY'S MILK FOOD COCOA.

(Prepared by Allen and Hanbury.)

WE found on analysis of this well-known Milk Food Cocoa that it contained a considerable proportion of the theobromine, the characteristic alkaloid of pure cocoa.

The mineral matter was 4.5 per cent., the fat from 17 to 18 per cent., and the cold water extract was as much as 64 per cent.; this latter figure agreeing well with a previous analysis. The proportion of matter soluble in cold water is important, as the easy digestibility of a cocoa depends much on its ready solubility. This stamps the preparation as one in every way desirable for invalids and persons of weak digestive powers.

Literature.

SURGERY OF THE VERMIFORM APPENDIX. (a)

THIS is a book which can be recommended to all classes of medical men, whether senior students, physicians, or surgeons. The subject is dealt with in a simple and methodical manner, rarities and obscure theories being absent or barely mentioned, so that the practical lesson which the authors essay to teach may not be obscured.

Much has been written upon diseases of the appendix, and there are still very divergent opinions held as to the part surgeons should play in their treatment. The present volume is a very concise *resumé* of the literature combined with the authors' well-known experience.

The subject of operation is dealt with fairly and dispassionately, but perhaps the directions when to operate might be stated in a more dogmatic manner. Dealing with the signs, symptoms, and pathology and indicating how cases should be individually judged is both honest and scientific, but in a short work of this character, which will be largely made use of by busy practitioners, dogmatism might save more lives than absolute accuracy. The subject treated of is one of absorbing interest, and the authors' method of treating it is pleasant and encourages thought.

INDEX-CATALOGUE OF THE U.S. LIBRARY. (b)

THE present volume of this great series of folios includes 8,706 author-titles, representing 2,599 volumes and 8,291 pamphlets, and 31,481 titles of articles in periodicals. In the first series the letter "L" terminated in the first third of the eighth volume; in this, the second series, it occupies the whole of the ninth volume, which includes the modern bibliography of labour, larynx, latrines, lens, leprosy, lichen, life-insurance, lips, lithotomy, liver, London, lungs, lupus, and so forth. Up to and including the present volume the series contains 267,231 author-titles, 239,518 book-titles, 238,444 pamphlet-titles, and 790,144 article-titles. The value of the series is known and appreciated by all students of medical literature who find their labour much lightened by reference to these ponderous volumes, which play the double part of facilitating the labours of the student and ensuring that the claims to originality that are based on ignorance of the past of medical literature will not have any

(a) "The Surgery of the Diseases of the Appendix Vermiformis and their Complications." By William Henry Battle, F.R.C.S., and Edred M. Corner, M.B., F.R.C.S. Pp. 208. Illustrations 11. Price 7s. 6d. net. London: Archibald Constable and Co. Ltd. 1904.

(b) "Index-Catalogue of the Library of the Surgeon-General's Office, United States Army: Authors and Subjects." Second series, Vol. IX. By L. Lyurl. Washington: Government Printing Office. 1904.

grounds for their existence. All who use the Index-Catalogue must feel grateful to the great Republic for its liberality in attempting and carrying out such a stupendous undertaking and so richly endowing medicine with such a valuable gift.

HOME NURSING AND HYGIENE. (a)

THIS handbook is the official publication of the St. Andrew's Ambulance Association. The subjects embraced by this small manual are somewhat extensive, but the authors have succeeded in condensing them within a very limited compass. No point of any importance in the nursing of the sick seems to have been omitted. There are altogether ten chapters, of which the first six are devoted to subjects connected with home nursing. The next three treat of hygiene, under the headings of "The House," "Food," and "Personal Health," while the last chapter deals with bandaging and surgical nursing generally. The volume as a whole forms a very suitable text-book, and one which will be of equal value to hospital nurses and to ambulance students. It will doubtless find many readers outside the class for whom it has been more especially prepared.

Medical News.

French Congress of Climatotherapy and Hygiene.

IT has been decided to hold the second Congress of the Association of French Physicians, especially interested in Climatotherapy at Arcachon, from April 24th to 29th. The district is one of the most beautiful on the Continent, and a most successful meeting is anticipated. Dr. Renant, Professor of the Faculty of Medicine of Lyons has been elected President and Dr. Festal of Arcachon, General Secretary, to whom all communications from members of the profession in Great Britain desirous of being present should be addressed. A welcome is assured to English medical men.

Cairo School of Medicine.

AT the dinner given recently at the School of Medicine, Cairo, Dr. Wm. St. Clair Symmers, who is leaving the service of the Egyptian Government to take up his appointment of Professor of Pathology at Belfast, was the guest of the evening.

Among those present were Dr. H. P. Keatinge, Director of the Cairo Medical School, Dr. Ibrahim Hassan Pasha, Dr. G. Elliott-Smith, Dr. W. H. Wilson, Dr. J. R. Naylor, Dr. A. Looss, Dr. W. A. Schmidt, Mr. F. R. Milton, Dr. P. C. Tribe, Dr. E. C. Fischer, Prof. L. P. Phillips, Prof. F. C. Madden, Dr. Harold Nolan, Dr. Shukry Bey, Dr. Innes Bey, Dr. Arloing, Dr. F. M. Sandwith, Mr. Reginald Harrison, and Dr. Charles Todd. Dr. Ibrahim Hassan Pasha gave the toast "Prosperity to the School of Medicine," and Dr. Keatinge proposed the health of Dr. Symmers. The toast was drunk with musical honours, after which Dr. Keatinge presented Dr. Symmers with a silver bowl, subscribed for by past and present professors of the Cairo Medical School. Dr. Keatinge then proposed the health of the visitors, coupled with the names of Dr. Arloing (Lyons University) who is studying cattle plague at Cairo, and Mr. Reginald Harrison (London). Dr. Arloing, who spoke in French, and Mr. Harrison responded, and the proceedings terminated.

St. Thomas's Hospital.

THE following gentlemen have been selected as house officers from Tuesday, March 7th, 1905:—

Resident House Physicians.—R. E. Whitting, M.A., M.B., B.C.Cantab., F. A. Brodribb, M.R.C.S., L.R.C.P., A. G. Gibson, B.A., M.B., B.Ch.Oxon., B.Sc.Lond. (extension), K. Takaki, M.R.C.S., L.R.C.P. (extension).

House Physicians to Out-Patients.—H. R. Dean, B.A., M.B., B.Ch.Oxon., M.R.C.S., L.R.C.P., A. C. Inman, M.A., M.B., B.Ch.Oxon.

(a) "Home Nursing and Hygiene." By J. Wallace Anderson, M.D., F.F.P.S.G., and George H. Edington, M.D., F.F.P.S.G. Illustrated, 1s. net. Glasgow: St. Andrew's Ambulance Association. 1904.

Resident House Surgeons.—H. A. Kisch, M.R.C.S., L.R.C.P., G. R. Footner, B.A.Cantab., M.R.C.S., L.R.C.P., R. E. G. Gray, M.A.Cantab., M.R.C.S., L.R.C.P., J. C. F. D. Vaughan, M.R.C.S., L.R.C.P.

House Surgeons to Out-Patients.—L. E. C. Norbury, M.R.C.S., L.R.C.P., D. K. Cutts, M.R.C.S., L.R.C.P., J. H. Bletsoe, M.B., B.S.Lond., M.R.C.S., L.R.C.P., R. J. C. Thompson, M.R.C.S., L.R.C.P.

Obstetric House Physicians.—(Senior) A. W. Parry, M.R.C.S., L.R.C.P., (Junior) N. C. Carver, B.A., B.C.Cantab., M.R.C.S., L.R.C.P.

Ophthalmic House Surgeons.—(Senior) A. B. Bradford, M.B., B.S.Durh., M.R.C.S., L.R.C.P., (Junior) F. R. E. Wright, M.B.Lond., M.R.C.S., L.R.C.P., D.P.H.

Special Departments:—*Throat*, W. G. Howarth, B.A.Cantab., M.R.C.S., L.R.C.P., G. J. Langley, M.B., B.S.Lond.; *Skin*, W. Haward, M.B., B.S.Durh., M.R.C.S., L.R.C.P., N. Carpmal, F.R.C.S., L.R.C.P.; *Ear*, J. H. Drew, M.R.C.S., L.R.C.P., C. Ll. Morgan, M.R.C.S., L.R.C.P.

Electrical Department.—F. Fowler, M.R.C.S., L.R.C.P. L.S.A.,

X-Ray Department.—H. M. Thomas, M.R.C.S., L.R.C.P.

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 24th ult.

There were present Dr. de Havilland Hall (in the chair), Dr. M. Greenwood, Mr. H. P. Symonds (Oxford), Dr. J. Bindrey James, Mr. F. S. Edwards, Mr. Edward Bartlett, Mr. William Thomas (Birmingham), Dr. Frederick S. Palmer, Dr. F. J. Allan, Dr. W. Knowsley, Sibley, and Dr. T. B. Ball.

The Committee examined a long list of sickness claims, the majority of which have been received from members of the Society in country practices, who are necessarily much exposed to bad weather in the early season of the year. The claims, though numerous, are mostly of short duration.

The Committee resolved to pay a cash bonus to those members of the Society whose certificates had been less than three years in force on December 31st, 1898, and who accordingly did not participate in the allotment of surplus then made. It is hoped that these bonuses will be paid before the annual general meeting, to be held in May next. Prospectuses and all particulars of Mr. F. Addismitth, Secretary Medical Sickness and Accident Society, 33, Chancery Lane, London, W.C.

Royal College of Surgeons, Ireland.

Fellowship Examination.—Miss A. F. M. Cornell, L.R.C.S.Edin., &c., having passed the necessary examination, has been admitted a Fellow of the College. The following candidates passed the primary part of the Fellowship Examination:—Mr. J. Campbell, L.R.C.S.I. &c.; Mr. H. B. H. Cunningham, M.R.C.S., Eng., &c.; Mr. D. Adams, Mr. R. M. Bronte, Mr. J. D'Alton, Mr. P. G. T. Elvery, Mr. J. B. Hanafin, Mr. F. M. Hewson, Mr. J. Molyneux, Mr. C. Sheahan, Mr. T. Sheeby, and Mr. G. F. Shepherd.

Diploma in Public Health.—The following candidates passed the Conjoint Examination for the Diploma in Public Health:—Mr. E. A. Bourke, L.R.C.S.I., &c.; Mr. P. T. Bolger, F.R.C.S.I.; and Mr. S. G. Gordon, L.R.C.S.I., &c.

Licence in Dental Surgery.—Mr. T. Flanagan having passed the necessary examination was admitted a Licentiate in Dental Surgery. Mr. A. E. Weinstock passed the primary part of the Dental Examination.

THE medical study tour in Germany this year will start from Munich on September 13th. The tour will comprise visits to the following watering places: Ischl, Reichenhall, Berchtesgaden, Gastein, Gossensass, Levico, Roncegno, Riva, Gardone, Solo, Arco, and Meran, where the tourists will arrive in time for the meeting of the German Association of Scientists and Physicians.

Notices to Correspondents, Short Letters, &c.

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

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 re-forwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

BOTANIST.—Hundreds of tons of weeds are exported yearly from Europe to the United States. Last year ten tons of poison hemlock, fifteen tons of tansy, and sixty tons of horehound were sent. Burdock is largely used there for its supposed virtues in diseases of the blood-system.

DR. M. (Hatfield).—Your question as to sugar as a food is very a propos just now. Sir William Gull recommends dried raisins and chocolate, which, he says, furnish a supply of sugar during any unusual expenditure of energy. Most athletes are aware of this. It is said the health of our army in S.A. was helped in no small degree by the supply of sugar in jam.

TURNING THE TABLES.

THE Daily News, usually a mine of universal information, had the following note last week:—"Dr. William Osler," says a New York telegram, "admits that he was only joking when he suggested that sexagenarians should be chloroformed." The world breathes again! The news reminds us to be thankful for the existence of the Atlantic cable service. But for ocean telegraphy, we might have lingered for days under the awful delusion that Dr. William Osler was serious. And, by the way—who is Dr. William Osler? Anybody know? The *Daily News* has clearly been hoaxed by Professor Osler, and seeks to turn the tables by affecting ignorance of his personality.

MEDICINE AND COMMERCE.—Members of the profession desirous of an appointment as Medical Attendant to a commercial house of standing, will find one advertised in our to-day's issue by Messrs. Cadbury Brothers, who employ 4,000 workpeople. We understand the salary attached to the post is considerable.

DR. MENESTRIER (Paris).—Your paper was duly received, and is marked for early insertion.

DR. A. D. F.—The communication in its present form is too long for our space. If you can reduce it to one-half, we will return it for your perusal.

D. P. H. (Leeds).—Dr. Hamer, Assist. M.O.H. of the L.C.C., gave as his opinion, after twelve years of serving, that the East End Aliens were most ready to conform to sanitary requirements.

DR. R.—Beer drinkers are probably more liable to multiple peripheral neuritis than spirit drinkers. It is a common affection in Lancashire among alcoholics, and in the past has perhaps been often due to arsenical impurities as first shown in the Manchester epidemic.

SPRONG.—A mineral water used in its potable sense must be regarded as a food product. Some waters contain traces of iron, lithium, sodium carbonate, and chloride, and have therefore a medicinal value.

OUT-patients frequently try the doctor's patience by long wiled explanations of symptoms real and imaginary, but recently a small boy came to be treated bearing a grubby note which briefly stated, "Bill as beliake."

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MARCH 8th.

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY (20 Hanover Square, W.).—8.30 p.m. Discussion on the Ethics of Health Resort Treatment (opened by Dr. L. Williams).

DERMATOLOGICAL SOCIETY OF LONDON (11 Chandos Street, Cavendish Square, W.).—5.15 p.m. Demonstration of Cases of Interest.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus, E.C.).—8.30 p.m. Pathological Evening. Exhibition of Specimens.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. J. Cantlie: Clinique. (Surgical.) 5.15 p.m. Dr. F. J. McCann: The Treatment of Puerperal Septicæ.

CENTRAL LONDON TROAT AND EAR HOSPITAL (Gray's Inn Road, W.C.).—5 p.m. Demonstration:—Mr. Nourse: Nasal and Aural Accessory Sinuses.

THURSDAY, MARCH 9th.

BRITISH GYNÆCOLOGICAL SOCIETY (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Dr. F. Edge. Paper:—Dr. I. Parsons: The Choice of Treatment for Fibromyoma of the Uterus.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM, 11, Chandos St., Cavendish Square, W.—8 p.m. Clinical Meeting. Cases will be shown by Mr. E. Chatterton, Mr. C. Blair, Mr. A. Ogilvy, Mr. J. H. Parsons and Mr. A. Lawson, Mr. J. H. Parsons, Mr. R. E. Bickerton, Mr. H. McMullen.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Mr. A. H. Tubby. Orthopedic Surgery.

FRIDAY, MARCH 10th.

THE INCORPORATED SOCIETY OF MEDICAL OFFICERS OF HEALTH (9, Adelphi Terrace, Strand, W.C.).—7.30 p.m. Discussion of the Causes of the Increased Prevalence of Anthrax in Great Britain (opened by a paper read by Prof. S. Delepine).

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8.15 p.m.—Mr. J. Berry will exhibit a Case, showing the Result of a Rhinoplasty Operation: a paper will be read at a subsequent meeting. 8.30 p.m. Papers:—Dr. W. H. White: A Case of Acute Rheumatoid Arthritis (with epididymo-epididymitis demonstration).—Dr. E. Abrahams: Arthritis Deformans and its Allies.—Mr. D. Drew: Three Cases of Stenosis of the Ureter.

BRITISH RHINOLOGICAL, LARYNGOLOGICAL, AND OTOLOGICAL ASSOCIATION (Medical Society's Rooms, 11 Chandos Street, Cavendish Square, W.).—4 p.m. Cases will be shown by Mr. C. Nourse, Dr. P. H. Abercrombie, Dr. Kelson, Dr. W. Wingrave, Dr. Lodge, Mr. H. Barwell, and Dr. A. Wylie. Discussion on Dr. J. S. Wallace's paper on Nasal Obstruction and Mouth Breathing.

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

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Lecture:—Dr. E. M. Leslie: Prognosis in Acute Pulmonary Affections.

TUESDAY, MARCH 14th.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Dr. E. M. Leslie: Prognosis in Chronic Pulmonary Affections.

Vacancies.

Navy Medical Department.—Three Dental Surgeons for Portsmouth, Plymouth and Chatham. Salary £1 per diem and travelling expenses when necessary. Applications to the Director General, Medical Department of the Navy, 18 Victoria Street, S.W. (See Advt.)

Birkenhead Union.—Resident Assistant Medical Officer. Salary £120 per annum, with board, washing, and apartments. Applications to John Carter, Clerk to the Guardians, Poor-law Offices, Birkenhead.

Lincoln County Hospital.—Senior Male House Surgeon. Salary £100 per annum with board, lodging, and washing. Applications to the Secretary, 2 Bank Street, Lincoln.

Paddington Green Children's Hospital, London, W.—Matron. Salary £100 per annum, including washing allowance. Applications to the Secretary, Paddington Green Children's Hospital, London, W.

Herts County Asylum, Hill End, St. Albans.—Junior Assistant Medical Officer. Salary £150 a year, with board, lodging, and washing. Applications to the Medical Superintendent.

Leeds General Infirmary.—Resident Casualty Officer. Salary £100 a year, with board, lodging, and washing. Applications to Thomas Blair, General Manager.

Bradford Children's Hospital.—House Surgeon. Salary £100 per annum. Applications to C. V. Woodcock, Secretary.

North Cambridgeshire Hospital, Wisbech.—Male Resident Medical Officer. Salary £100 per annum, with furnished rooms, attendance, coals, gas, and washing. Applications to William F. Bray, Secretary, Wisbech.

Royal Dental Hospital of London.—School of Dental Surgery, Leicester Square, W.C.—Demonstrator of Practical Dental Surgery. Salary £100 per annum. Applications to the Dean.

Hydropathic Establishment.—Resident Medical Officer. Salary £200 per annum, with free quarters for medical officer and his wife. Applications to the Schoolastic, Clerical, and Medical Assn., Ltd., 22 Craven Street, Trafalgar Square, W.C.

Messrs. Cadbury Bros.—Factory Medical Attendant for their 4,000 workpeople. Preference given to a total abstainer. For Particulars address "B.C." at Bournville. (See Advt.)

Appointments.

ALDOUS, G. F., F.R.C.S. Edin., Assistant Surgeon to the East Cornwall Hospital, Plymouth.

BRADLEY, J., Certifying Surgeon under the Factory and Workshop Act for the Gortin District of the county of Tyrone.

FOX, E. L., M.D. Cantab., Physician to the East Cornwall Hospital, Plymouth.

GRÜNER, O. C., M.B. Lond., Honorary Pathologist to the Leeds Public Dispensary.

KILICK, C. R., M.B. Lond., L.S.A., Certifying Surgeon under the Factory and Workshop Act for the Williton Districts of the county of Somerset.

LUCY, R. H., K.B., C.M. Edin., Surgeon to the East Cornwall Hospital, Plymouth.

MORRICE, George Gavin, M.A., M.D. Cantab., M.R.C.P., Physician to the Dorset County Hospital.

Births.

BOUSFIELD.—On March 2nd, at 35 Princes Square, W., the wife of Stanley Bousfield, M.A., M.B., of a son.

Marriages.

STEEN—BARNES.—On March 1st, at St. Mary's Church, Twickenham, Robert Hunter Steen, M.D. Lond., Medical Superintendent of the City of London Asylum, Stone, to Alice, daughter of the late Lawrence Barnes, of Ealing.

Deaths.

GORDON GREEN.—On March 2nd, at 85 Waverley Road, Southsea, George Gordon, the infant son of Staff-Surgeon Henry William and Maud Gordon Green, aged six weeks.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXX.

WEDNESDAY, MARCH 18, 1905.

NO. II.

Original Communications.

REMARKS ON LOCALISED FLUSHING AND SWEATING OF THE CHEEK ON EATING, ALSO ON "STRIÆ PATELLARES."

By F. PARKES WEBER, M.D., F.R.C.P.,
Physician to the German Hospital, London, and to the
Mount Vernon Hospital for Consumption, Hampstead.

THE patient in question is now aged 26½ years. (a) When he eats anything solid (for instance, a piece of sugar or an apple) a patch of redness appears almost immediately on the left side of the face as if he had received a sharp blow on the cheek. The reddened area is very hot, and sweating quickly follows. Occasionally a much smaller area of redness and sweating appears on the right side of the face, in front of the lobe of the ear, when the phenomena on the left side are at their maximum. The swallowing of fluids, such as milk, &c., does not cause the flushing and sweating to appear, but the rolling of a little vinegar and water about in the mouth (without biting or swallowing) calls forth the curious reaction fairly promptly. The reaction commences more quickly when he uses his teeth on the right side for biting his food than when he uses those on the left side. By merely opening and shutting his jaws or chewing a piece of wood (by pretending to eat) a very slight degree of redness is all that can be produced. The flushing and sweating subsides two or three minutes after he leaves off eating, but it takes a longer time for the redness to completely disappear. It was found that the phenomena were somewhat less marked when a cocaine lozenge was taken before his food, but the use of these cocaine lozenges has not been encouraged. A similar diminution in the symptoms followed treatment by bromide and belladonna (10 minims of the tincture three times daily) internally, and belladonna liniment externally. The effect of belladonna in checking unilateral and local sweating has been specially noted by Ringer. After much mental worry a middle-aged man suffered from excessive sweating of both cheeks, coming on while eating (especially hot meat or vinegar), but ceasing immediately after the meal. This sweating was completely stopped by ten drops of tincture of belladonna three times

daily. (Ringer and Sainsbury's "Therapeutics," thirteenth edition, 1897, p. 527.)

A case somewhat similar to the present was recorded by W. H. Haynes (*New York Med. Journ.*, December 25th, 1897) in a girl, æt. 19, of neuropathic ancestry. Any sweet or sour substance, when placed in her mouth, caused immediately, together with the flow of saliva, the whole of the right side (which was larger than the left side) of her face to become scarlet and noticeably enlarged, the phenomena subsiding very soon after removal of the determining cause in the mouth. In the present case there is no neuropathic family history. The patient suffered from appendicitis in December, 1894, and the appendicitis was followed by parotid buboes on both sides of the face, which had to be opened, and the scars of which still remain. About March, 1895, he was operated on for the appendicitis, and it was after that operation that the flushing and sweating of the face were first noticed. I believe the most probable explanation of the phenomenon to be that some sympathetic nerve fibres are involved in scar tissue (on both sides, but chiefly on the left side) and are stretched or pulled on owing to the physiological swelling of the salivary glands during eating. There is very slight diminution of tactile sensation in the neighbourhood of the scars. Suppuration of the parotid has been known to have been followed by sweating of the face. Mr. R. J. Godlee has kindly given me an instance of this sequence of events in the case of a middle-aged woman. In 1901, whenever she ate any solid or sharp-tasting food a red flush appeared almost immediately, which was very annoying. The history was that a parotid bubo on each side of the face followed an abdominal operation in 1890; these had to be opened and got well. But in 1901 there was recurrence of the swelling, together with ear disease; this was followed by the peculiar flushing on one side. In the present case no localised sweating or flushing occurs when the patient becomes hot by exercise or excitement, and there are no pupillary or other phenomena indicating any involvement of the rest of the cervical sympathetic. The patient's general health is now good. The appendicitis scar is healthy, and there is no sign of present disease of the thoracic and abdominal viscera or of the central nervous system. The diminution of hearing on the left side is due to old middle-ear disease. The knee-jerks are natural.

The rather uncommon atrophic transverse scars in front of this patient's knee-caps, and just above them, known as *striae patellares*, are

(a) The case was shown by Dr. Weber at a Clinical Evening of the Clinical Society on October 22nd, 1897, and again on January 27th, 1905.

peculiarly well marked and long. Like lineæ gravidarum and the lineæ due to obvious distension of the skin by ascites, œdema, obesity and local tumours of any kind, striæ patellares and other so-called "idiopathic" striæ sometimes met with about the shoulders, elbows and thighs of young growing persons doubtless originate from gradual rupture of the deeper layers of the cutis. Striæ patellares sometimes occur below as well as in front of and above the patellæ; sometimes they are better marked on the outer side of the joint, and they are not always symmetrical in the two limbs. In the present case they were first noticed after the attack of appendicitis ten years ago, and therefore were probably a result of the patient lying in bed with his knees flexed, the skin in front of the knees being thus tightly stretched at a time when he was growing rapidly and when his general nutrition was greatly affected by the appendicitis. Striæ patellares have been more frequently noticed after typhoid fever than after other febrile diseases, such as scarlet fever, pneumonia, appendicitis and colitis. My colleague, Dr. Zum Busch, kindly showed me an excellent example of striæ patellares in a young man at the German Hospital, in whom they probably arose when he suffered from osteo-myelitis about ten years previously.

Similar striæ after febrile diseases sometimes occur in other positions, as the arms, loins and outer surfaces of the thighs. Sir Dyce Duckworth (*Brit. Journal of Dermatology*, 1893, vol. v, p. 357) recorded striæ across the outer part of the left thigh after typhoid fever in a boy, æt. 15. There were similar parallel stripes on the outer side of each leg above the malleolus. In that case the excessive hyperæsthesia of the skin in the distribution of the external and middle cutaneous nerves suggests the presence likewise of the condition now generally known as "meralgia paræsthetica" (W. K. Roth, 1895), or "Bernhardt's paræsthesia" of the thigh (*Neurologisches Centralblatt*, 1895, p. 242), of which three years ago I met with a typical example following suppuration connected with vaccination (*Brain*, Summer, 1902, p. 353). The meralgia paræsthetica in my case gradually disappeared completely in the course of eight or nine months.

Excellent papers on the nature and cause of "striæ patellares" have recently been published by G. Fischer (*Münchener med. Woch.*, 1904, No. 11, p. 482), H. Köbner (*ibid.*, 1904, No. 21, p. 928), and J. L. Bunch (*British Journal of Dermatology*, January, 1905, p. 1). Actual microscopic examination of the striæ shows that they are due to rupture or "cleavage" of the deeper layers of the cutis, but much remains to be worked out in regard to their etiology, and especially their relation to stretching of the skin, growth of long bones and typhoid fever. I would only point out that at the height of the fever in cases of typhoid fever there may be a peculiar nutritional condition of the skin present. It is well known that chronic psoriasis sometimes more or less completely disappears during typhoid fever, to generally reappear sooner or later after recovery from the fever. Small wounds made during the height of the fever (as in opening small abscesses) have a tendency to gape in a most peculiar manner before they ultimately heal up by granulation. Some time since, in a grave typhoid fever case, a boil on the

front of the thigh was incised, and I observed that in the course of the next day the skin retracted so much that the small incision came to appear like a big fissure in the skin, the wound afterwards healing by granulation. Possibly in some cases the tendency to skin cleavage during typhoid fever may be partly due to the presence of excessive diarrhœa, which increases the ordinary febrile dryness of the tissues. It is not right to infer that because active growth of long bones, continued flexion of joints, and typhoid and other febrile diseases are not usually followed by "striæ patellares" or by similar striæ in other positions, therefore the striæ arise altogether independently of such supposed causes. By a similar line of argument one would arrive at once at the conclusion that tabes dorsalis and general paralysis of the insane had no connection with syphilis.

There are certainly very few cases of these cutaneous striæ remaining in which none of the causes referred to (not even active growth of long bones) can be ascertained, and which can really be classed as "idiopathic." Doubtless, however, a personal disposition plays a great part in the development of those striæ which are not obviously due to stretching. In 1897 I saw a well-developed muscular clerk, æt. 17, who had typical striæ over his shoulders, somewhat in the direction of the fibres of the deltoid muscle. Owing to their freshness they had a bluish, not a white appearance, and could therefore not as yet be literally termed striæ albicantes. There had been no illness, accumulation of fat, or œdema to account for the skin cleavage in that case, but the boy was growing rapidly.

A NEW FORM OF UTERINE DILATOR.

By ALEXANDER DUKE, F.R.C.P.

FOR those numerous gynæcologists who still prefer the Hegar dilator to the various other forms of divaricating make, the instrument depicted will, I venture to say, be found in practice an improvement.

It consists of a central metal rod, perforated from end to end (this offering much less resistance in introduction than the solid form, and also permitting of the escape of any existing secretions). *This need not be withdrawn after introduction till full dilation is effected.*

The four sides of central rod, from inch of point, are grooved, allowing the easy introduction of the four side pieces (seen in illustration) *one at a time*, according to the additional expansion required.

When these have been slid along the grooves full length, the amount of dilatation gained should equal a much larger number of Hegar's solid rods, introduced consecutively. This unilateral expansion carried on at short intervals by the introduction of the sliding side pieces I consider an advantage, and will, I think, ensure the dilatation required, with the expenditure of less time, less pain to the patient (if not anæsthetised), and less force on the part of operator.

The perforation in centre rod can also be used through which to inject some lubricating oil or glycerine (during or after introduction), and which, by gravitating outwards, should facilitate the sliding action of the side pieces

in addition. Any sized dilator can be made on this plan, and I should imagine a large size might be found useful in cases of eclampsia, where rapid delivery was imperative, in place of



the formidable instruments with screw, which are more than likely, even in skilled hands, to produce lacerations. The application of a 10 per cent. solution of eucaine or cocaine for ten minutes previously to cervix should facilitate introduction by the relaxation produced, and also mitigate pain in those cases where general anæsthesia is not considered advisable.

Firm pressure from above, over uterus by left hand will, I think, be found to facilitate the introduction of dilator better than traction on cervix by volsella or tenaculum. The instrument has been neatly made for me by Messrs. Hewlett and Son, Charlotte Street, E.C.

FŒTID BRONCHITIS.

By DR. BARBIER,
Of the Faculty of Medicine of Paris.

FŒTID bronchitis is characterised by a group of symptoms which may be classified as follows:—In most instances the patient has for years been suffering from dilated bronchi. The general health may be fairly good and the local lesions may have been stationary for years, when, all at once, disquieting manifestations supervene. The temperature suddenly rises to 102° F. or 104° F., with shivering and sharp intra-thoracic pain. There is obstinate cough, occurring in paroxysms of some duration, and, lastly, the expectoration is fœtid. Sometimes this fœtor makes its appearance quite suddenly, and one is surprised to find that the sputum, which was previously merely musty without anything characteristic, all at once becomes horribly fœtid. At other times, on the contrary, the fœtor of the sputum is preceded by gradually-increasing fœtor of the breath. The latter is usually not very marked, and must be sought for, but it is soon followed by fœtor of the sputum. When this occurs the character of the sputum changes; it becomes more liquid and of a greyish colour, and it separates in the spittoon into several layers, assuming, in fact, appearances somewhat similar to those of pulmonary gangrene. The fœtid bronchorrhœa lasts for a variable period, then ultimately disappears, or else causes death by hectic fever, and, more particularly, by gangrene of the lung.

These are the general features of the disease, but it

will be well to study each symptom somewhat more in detail. I have stated that fœtid bronchitis most commonly occurs in the subjects of dilated bronchi, and is ushered in by an aggravation of the constitutional condition, along with special manifestations, the most important being fœtor of the sputum. Fœtor of the breath and expectoration usually makes its appearance in the course of old-standing bronchiectasis, whence the name fœtid bronchorrhœa, or fœtid bronchiectasis, is sometimes given to this variety of putrid bronchitis. It is the most characteristic feature of the fully-developed disease. Eichhorst gives us an excellent description of the sputum. It is profuse, and the liquid is greenish-brown, clayey, or blood-streaked. After a time it separates into a lower sedimentous layer, a thin sero-liquid middle layer, and an upper frothy layer containing muco-purulent masses. In the lowest layer we find the peculiar formations described by Dittrich under the name of myotic bronchial plugs. These vary in size from a pin's head to a large pea. They are white or grey or brown, the more recent they are the lighter being the tint. They have the consistence of porridge, and when squeezed flat they give off a foul odour. Histologically these plugs are formed of granular debris itself, made up of filaments and spores. Leyden and Jaffé gave the name *Leptothrix pulmonalis* to these spores, and they mention that when treated with tincture of iodine they take on a brownish-yellow or violet-blue colour. Dittrich's plugs also contain pus corpuscles, especially when recent, spirillæ, the remains of red corpuscles and fatty acids, the closely-packed needles whereof form a lace-work which might very well be mistaken for elastic tissue.

Chemical analysis of these plugs led Jaffé to conclude that they are formed of fatty acids, leucine, tyrosine, sulphuretted hydrogen and ammonia. Filchner and Saltnikoff have isolated from the putrid expectoration a ferment having the same action as trypsin.

These are indeed the principal characters of the expectoration in fœtid bronchitis, but we may complete the description by a few additions. For instance, authors insist on the copiousness of the expectoration, but this need not excite surprise considering that the disease occurs in the course of a fœtid bronchorrhœa. In fœtid bronchitis, says Dr. Barié, the catarrhal secretion is very abundant, especially when there is a tendency to bronchiectasis. Even the appearance of the sputum varies. Sometimes it answers closely to the description given by Eichhorst, sometimes it is more liquid, and of a greyish colour (Classic). However this may be, placed apart in a receptacle, the expectoration invariably separates into several layers, of which the lowest contains the plugs described by Dittrich. The fœtor of the expectoration is the most characteristic feature, but this varies within wide limits. In some cases it is as marked as in typical pulmonary gangrene, but as a rule it is merely disagreeable, more or less fœtid, but *à la rigueur* supportable, not the fœtor described so vividly by Trouseau as one that "nauseates a whole wardful of patients." The odour is less suggestive of decomposition than of mere mustiness; it may be sour or sweet, or resemble that of sulphuretted hydrogen, while in mild cases the fœtor may only amount to acidity. This symptom, however, may be wanting for long periods of time; indeed, a feature to which special attention has been called by a number of observers is the intermittent character of the fœtor. It appears and disappears at irregular intervals, without apparent cause, and in spite of every kind of treatment. This very intermittence is of great assistance in arriving at a differential diagnosis between putrid bronchitis and true pulmonary gangrene. Long before the sputum becomes distinctly fœtid patients often complain of foul breath, a disagreeable odour of decayed teeth or rotting fish. The fœtor increases as soon as the patient begins to talk or cough, when gusts of foul odour escape from the mouth and pollute the air for a considerable distance round.

The other functional signs do not present anything very characteristic; the cough is variable and is in no wise peculiar, and the same remark applies to the dyspnoea, which depends more on the causative lesions than upon the bronchitis. Lastly, hæmoptysis is rare, and it never assumes the character that it presents in pulmonary gangrene.

With respect to the physical signs, all we can say is that if the foetid bronchitis supervenes on the top of bronchial dilatation, the physical signs are those of a bronchiectatic cavity and, in other words, the characteristic signs of foetid bronchitis are purely functional, the physical signs being common to bronchitis, whether complicated or not with bronchiectasis.

The general signs vary according to the stage of the disease. At the onset the general health may be pretty good, the temperature, raised to begin with, soon falls to normal, the appetite remains good, the tongue is not furred, the liver and spleen are not increased in size, and there is no albumin in the urine. In such cases the patient complains of nothing more than discomfort, and the whole history of the malady might be summed up in the words—foetid bronchitis. This benignity, however, is by no means the rule. The constitutional disturbance may be such as to threaten life, and, after a variable lapse of time, very grave complications may occur, especially pulmonary gangrene, the inevitable ultimate termination of most cases of bronchial gangrene.

But patients do not reach this terrible extremity all at once. Usually, after a time, the foetus of the breath and sputum subside, the general condition improves, and for weeks, months or even years the patient appears justified in believing that he is cured. This is, indeed, the characteristic intermittence, for the fugitive, ephemeral nature of the accidents is one of the most certain and constant signs of foetid bronchitis; it is also one upon which authors are least agreed. This question of intermittence brings us to that of curability. Pulmonary gangrene is but rarely recovered from, whereas in foetid bronchitis recovery is the rule. The cure, however, may not be permanent, and the patient may ultimately succumb to cachexia or lapse into genuine pulmonary gangrene with septicæmia.

When death is due to progressive cachexia it is caused by the absorption of the products of putrefaction and to the hectic fever to which this absorption gives rise. There is diarrhoea, first occasional, then chronic, the pulse becomes small and imperceptible, and death supervenes in marasmus.

In a certain proportion of the cases the gangrenous process does not remain limited to the bronchial mucosa, but extends to the pulmonary parenchyma, whereupon we get patches of broncho-pneumonia, with amphoric breathing, gurgling and pectoriloquy, which reveal the existence of huge cavities within. The general health fails, the complexion becomes sallow, the temperature reaches 103° or 104° and remains there, and the foetus of the sputum goes on increasing until death closes the scene.

The only disease for which foetid bronchitis can be mistaken is gangrene of the lung. In the majority of cases the diagnosis is easy enough. In the latter the onset is more violent and sudden, and the constitutional symptoms are altogether graver; there is no remission, and recovery is altogether exceptional. In the other, the disease assumes a chronic course from the very beginning, the patients give a history of having suffered for years from more or less copious catarrhal secretion, with a stale odour, though sometimes the foetus may be extreme, as bad, indeed, as in true pulmonary gangrene, so that we cannot trust entirely to this sign to distinguish between them. The microscopical appearances of the sputum are the same in both, for in both the expectoration tends to separate into layers when left at rest, and in both we find Dittrich's plugs. The special point in pulmonary gangrene is the presence in the sputum of pulmonary tissue, with or without elastic fibres, recognisable as such. Further assistance in the differential diagnosis may be obtained by studying the antecedents of the

patient, by watching the course of the affection and of the stethoscopic signs. Lastly, the almost invariably unilateral distribution, behind and to the left, the prolonged duration of the disease without manifest impairment of health, and apyrexia associated with the auscultatory signs of a pseudo-cavity from the beginning, without being preceded by symptoms of consolidation; all these are points that militate in favour of putrid bronchiectasis.

Bronchial gangrene may, however, merge into pulmonary gangrene, in which case we must rely for its detection upon the rapid deterioration of the general health, the progressive adynamia and the alteration of the physiognomy, on the supervention of high fever and the exaggerated foetus of the sputum, associated with aggravation of the cough and dyspnoea, in addition to evidence of disseminated foci of broncho-pneumonia. The possibility of its occurrence must always be borne in mind.

The prognosis in foetid bronchitis being grave, a very large number of therapeutical methods have been brought to bear—inhalations of turpentine water (Skoda), of carbolised water, sprays of solutions of tannin, of extract of rhatany, of sulphate of copper, perchloride of mercury, arseniate of soda—agents which, conveyed into the lungs, might conceivably act upon the diseased surfaces and expedite recovery. Leyden often made use of inhalations of oxygen associated with the internal administration of carbolic acid.

The only internal remedies that appear to do any good in foetid bronchitis are tincture of eucalyptus and hyposulphite of soda. Tincture of eucalyptus is recommended by Dr. Bucquoy, who gives it in doses of 30 minims daily. According to Lancereaux, the best remedy is the hyposulphite of soda in doses of a drachm daily. In five or six days its administration is usually followed by decided lessening of the foetus and a reduction in the amount of the expectoration. Chauffard prefers tincture of benzoin in doses of 10 to 15 minims daily, associated with essence of myrtle in doses of from 15 to 20 minims daily. There is no reason why we should not combine several of them in one mixture, for instance, tincture of eucalyptus, 15 minims; hyposulphite of soda, 1 drachm; mucilage, 12 drachms. To be taken in dessertspoonful doses every two hours. When internal treatment fails Dieulafoy has recourse to counter-irritation of the chest, and he has often obtained marked improvement in respect of the foetus thereby.

The practitioner, in treating foetid bronchitis, must, of course, not neglect to attend to the general health, which is apt to suffer in consequence of the copiousness of the expectoration, the possibility of the absorption of septic matter and the existence of fever, which may lead to cachexia and hectic. The health should be maintained as far as possible by the aid of tonics and reconstituents comprising easily assimilated preparations of iron, the glycerophosphates, and so on.

THE VITALITY OF THE TYPHOID BACILLUS IN SHELLFISH. (a)

By E. KLEIN, M.D., F.R.S.,
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THE following tables contain a summary of the results of six separate series of experiments. These were made in order to ascertain the behaviour of the *Bacillus typhosus* in oysters, cockles, and mussels, either when these were separately and directly infected with a definite quantity of the microbe or when they were kept for 24 hours in sea water previously infected with a definite quantity of the microbe:—

EXPERIMENT I.

Clean Burnham Oysters: Each oyster received into the interior of the shell a little over 160,000,000 of *B. typhosus*. Half of the number of these oysters

(a) Preliminary Report on investigations on behalf of the Worshipful Company of Fishmongers, London.

were then placed in clean sea water, which was changed every 24 hours; the other half was not placed in sea water at all, but was kept "dry" in a cool chamber. The first lot will be designated "wet oysters," the other lot "dry oysters." Each oyster received over 160 millions *B. typhosus*.

Lot 1.—Wet Oysters:—

Oyster 1—After 1 day—	70,000 <i>B. typhosus</i> per oyster.
" 3— " 2 days—	9,100 " "
" 5— " 3 " "	1,100 " "
" 7— " 4 " "	320 " "
" 9— " 6 " "	0 " per $\frac{1}{10}$ oyster.
" 11— " 7 " "	0 " " $\frac{1}{10}$ "

Lot 2.—Dry Oysters:—

Oyster 2—After 1 day—	1,200,000 <i>B. typhosus</i> p. oys.
" 4— " 2 days—	175,000 " "
" 6— " 3 " "	42,000 " "
" 8— " 4 " "	3,700 " "
" 10— " 6 " "	40,000 " "
" 12— " 7 " "	1,220 " "

EXPERIMENT II.

Clean Colchester oysters were placed in sea water; in this water typhoid bacilli of culture were distributed to the amount of 744,000 *B. typhosus* per 1 c.c. Twenty-four hours after oyster 1 was analysed and found to contain in its body 40,000 *B. typhosus*. Then the oysters were separated into two lots, lot 1 being placed in fresh, clean sea water, which was changed every 24 hours; lot 2 was kept "dry" as above.

Oyster 1 after 24 hours in infected sea water, 40,000 *B. typhosus*.

Wet Oysters:—

Oyster 3—After 1 day in clean water	1,380 <i>B. t.</i> per oys.
" 5 " 2 days " "	440 " "
" 7 " 5 " " "	82 " "
" 9 " 6 " " "	44 " "
" 11 " 7 " " "	0 " "
" 13 " 9 " " "	0 " "

Dry Oysters:—

Oyster 2—After 1 day dry	40,000 <i>B. typhosus</i> per oys.
" 4 " 2 days dry	3,700 " "
" 6 " 3 " "	700 " "
" 8 " 5 " "	150 " "
" 10 " 6 " "	280 " "
" 12 " 7 " "	510 " "
" 14 " 9 " "	90 " "

EXPERIMENT III.

Of experiment II, 10 oysters (6 wet, 4 dry) were left over. These, there was reason to suppose, had become practically free of *B. typhosus*, with which they had been originally infected. Both lots, wet and dry, were then kept for several days in clean sea water, and were then transferred to sterile sea water, to which culture of *B. typhosus* was added to the amount of 2,250,000 *B. typhosus* per 1 c.c. After 24 hours the number of *B. typhosus* was determined of the sea water and of one oyster of each lot—i.e., of the lot 1 "previously wet" and of lot 2 "previously dry." The sea water was then changed every 24 hours.

Sea Water:—

Immediately after infection	2,250,000 <i>B. t.</i> per 1 c.c.
1 day after infection	126,000 " "
1 day after change	250 " "
2 days " " "	0 per $\frac{1}{10}$ c.c.
3 " " " "	0 " "
4 " " " "	0 " "
6 " " " "	0 " "

Previously Wet Oysters:—

Oyster 15—After 1 day	84,000 <i>B. t.</i> per oyster.
" 17 " 2 days	935 " "
" 19 " 3 " "	105 " "
" 21 " 4 " "	0 per $\frac{1}{10}$ part of oyster.
" 23 " 7 " "	0 " "
" 25 " 8 " "	0 " "

Previously Dry Oysters:—

Oyster 16—After 1 day	1,318,000 <i>B. t.</i> per oyster.
" 18 " 2 days	1,900 " "
" 20 " 3 " "	646 " "
" 22 " 4 " "	713 " "

EXPERIMENT IV.

Polluted oysters from the foreshore of Southend-on-

Sea. The outside of the shell was well brushed and cleaned, and the oysters were then placed in sterile sea water in a tub, to which culture of *B. typhosus* was added to the amount of 2,470,000 *B. typhosus* per 1 c.c. In this infected water the oysters remained for 24 hours; then the sea water of the tub was tested, as also one oyster. The oysters were then taken out, the tub was well cleaned, and received fresh sterile sea water. The oysters were divided in two lots. Lot 1 were replaced in the clean sea water—"wet oysters." Lot 2 were not replaced in sea water, but were kept "dry" in cool chamber. The sterile sea water was changed frequently.

Sea Water:—

Immediately after infection	2,470,000 <i>B. t.</i> per 1 c.c.
24 hours " "	1,530,000 " "
1 day after change " "	13,180 " "
2 days " " "	10,580 " "
4 " " " "	20 " "
6 " " " "	0 <i>B. t.</i> per 1-10 c.c.
8 " " " "	0 " "

Wet Oysters:—

Oyster 1—After 1 day in infected water	95,800 <i>B. t.</i>	90 <i>B. coli.</i>
" 3 " 2 days in clean	752,800 " "	no " "
" 5 " 4 " "	1,200 " "	" "
" 7 " 6 " "	200 " "	" "
" 9 " 7 " "	378 " "	" "
" 11 " 8 " "	56 " "	" "
" 13 " 9 " "	390 " "	" "
" 15 " 11 " "	0 per $\frac{1}{10}$ part of oyster.	" "

Dry Oysters:—

Oyster 2—After 2 days dry	58,700 <i>B. t.</i>	No <i>B. coli.</i>
" 4 " 4 " "	17,400 " "	" "
" 6 " 6 " "	37,900 " "	" "
" 8 " 7 " "	1,300 " "	" "
" 10 " 11 " "	oyster looked abnormal, shell closed very slowly. Innumerable <i>B. typhosus</i> , very large number of <i>B. coli.</i>	

EXPERIMENT V.

Several dozen cockles were placed in sea water previously infected with *B. typhosus* of culture to the amount of four millions per 1 c.c. After 24 hours the cockles were taken out and washed; two were retained for analysis, the rest were transferred to clean sand wetted with clean sea water. This change—*viz.*, placed into clean sand wetted with clean sea water—was repeated several times in the course of ten days. The two cockles above referred to, which were examined 24 hours after having been kept in the typhoid-infected sea water, showed that each contained in its body about half a million of *B. typhosus* (120 *B. coli*).

Cockles 1 and 1a, after 24 hours in infected water,	contained each about 500,000 <i>B. t.</i>
Cockle 2, after one day's change,	contained 153,000 <i>B. t.</i> (no <i>B. coli</i>).
Cockle 4, after two days' change,	contained 382,000 <i>B. t.</i> (no <i>B. coli</i>).
Cockle 6, after five days' change,	contained 358,000 <i>B. t.</i>
Cockle 8, after six days' change,	contained 1,541,000 <i>B. t.</i>
Cockle 10, after seven days' change,	contained 138,600 <i>B. t.</i>
Cockle 12, after nine days' change,	contained 69,300 <i>B. t.</i>
Cockle 12a, after nine days' change,	contained 111,000 <i>B. t.</i>
Cockle 14, after ten days' change,	contained 1,600 <i>B. t.</i>
Cockle 14a, after ten days' change,	contained 69,000 <i>B. t.</i>
Cockle 14 was not quite normal; its shell did not close well.	

EXPERIMENT VI.

Several dozen mussels were placed in sea water infected with *B. typhosus* of culture to the amount of 5,170,000 *B. typhosus* per 1 c.c. Having been kept for 24 hours in the infected sea water, the mussels were washed in clean sea water; one was kept back for analysis, the remainder were transferred to a fresh clean tub with sterile sea water covered with seaweed. In this water the mussels remained for about six hours, after which time the bulk of the water was poured off,

leaving just sufficient to keep the mussels in the tub in a wet condition. By doing this we tried to imitate to some extent what occurs under natural conditions—*viz.*, mussels are not permanently immersed in the water like oysters, but during ebb remain uncovered by water. This same process—*viz.*, clean tub with fresh sterile sea water for six hours—was repeated every 24 hours as long as any of the mussels remained alive.

Mussel 1 (large), kept in infected sea water for 24 hours, contained over six millions *B. typhosus*.

Mussel 2 (medium sized), one day after change, contained 74,800 *B. t.*

Mussel 3 (large), two days after change, contained 628,660 *B. t.*

Mussel 4 (medium), three days after change, contained 36,000 *B. t.*

Mussel 5 (medium) five days after change, contained 58,450 *B. t.*

Mussel 6 (medium), six days after change, contained 6,250 *B. t.*

Mussel 7 (medium), seven days after change, contained 14,200 *B. t.*

All these mussels were in good condition, looked in every way normal, shell well closed. The experiment could not be continued on account of the difficulty of keeping them alive and normal. From the foregoing experiments I would draw the following conclusions:—

1. Oysters readily take up into their interior the *B. typhosus* which had been introduced into their shell or into the surrounding sea water.

2. Oysters, clean at starting, rapidly clear themselves of the ingested *B. typhosus*, if they are kept in clean sea water which is frequently changed.

3. Oysters, clean at starting, clear themselves of the ingested *B. typhosus* to a less extent and slower, if they are kept in a "dry" state—*i.e.*, out of the sea water.

4. Oysters from a polluted locality clear themselves of the ingested *B. typhosus* to a less extent and at a slower rate, even if kept in clean sea water, than oysters clean at starting.

5. Oysters from a polluted locality retain the ingested *B. typhosus* to a markedly larger extent if kept "dry"—*i.e.*, outside the water.

6. The process of "clearing themselves" of the ingested *B. typhosus* cannot be owing to the oyster merely "passing out" the ingested *B. typhosus*, but must be due to a large extent to an inherent power of the oyster of *directly devitalising the microbe*. The experiments with the "dry" oysters prove this, and it is also evident from the rapid rate at which this microbe disappears from the oysters kept in clean water if compared with the very small number of the microbe (*B. typhosus*) found at the same time in the surrounding sea water. (Experiments III and IV.)

7. Oysters which had been infected with *B. typhosus*, and which were then kept in a "dry" state till they had practically cleared themselves of the microbe, when subjected to re-infection with *B. typhosus* appear less capable of dealing with this microbe, even if they be kept in clean sea water, than the re-infected oysters which have always been kept in the water. This could be explained by the obvious supposition that oysters by being kept for some days out of the water, are not possessed of the same degree of vitality and activity of their tissues as oysters are which have always been kept under normal conditions—*i.e.*, in water.

8. Oysters from a polluted locality, and containing a large number of *B. coli*, very rapidly clear themselves of this microbe, both those kept in, as also those kept out of the water. This shows that *B. coli* is foreign to the oyster and is rapidly destroyed by it. (Experiment IV.) When, therefore, it is present in the oyster, it must have been derived from the surroundings.

9. However largely infected with the *B. typhosus*, the oysters at no time present to the eye any sign of such infection; they remain in all parts normal in aspect. This is the case not only with the infected oysters kept in sea water, but also with the infected oysters kept in the "dry" state. There was only one

exception—*viz.*, an oyster derived from a polluted locality, which oyster had been eleven days out of the water.

10. During the time of these experiments (part of September, October, and part of November) the oysters lived quite well in *sterile* sea water frequently changed. There was no alteration noticeable in the aspect of the fish; they remain plump and juicy, and capable of promptly and tightly closing the shell.

11. Cockles readily embody the *B. typhosus* present in the sea water. While the number of these latter appears at first to diminish in the body of the cockle, it soon increases to a considerable degree, for five days after the cockles had been removed from the infected water and kept in clean sand the number of *B. typhosus* exceeded three times the number initially present. Their subsequent diminution proceeded only slowly, since even ten days after their removal from the infected water the cockle examined still contained in its body 69,000 *B. typhosus*.

12. Mussels also readily embody the *B. typhosus*; in fact, the analysis seems to show that mussels do so to an extent greater than oysters or cockles. As regards the fate of the *B. typhosus* in the mussels, these appear to stand between oysters and cockles, since in mussels the *B. typhosus* undergoes gradual diminution, but this diminution is incomparably slower than in oysters, but takes place somewhat quicker than in cockles.

Clinical Records.

CASE OF FOREIGN BODY IN ŒSOPHAGUS.

Under the care of JOHN REID, M.D., B.Ch., B.A.
Bandon.

THE following case of a foreign body in the œsophagus is, I think, interesting from one or two unusual features—*viz.*, the size of the foreign body which could be swallowed to a certain distance by a young child; and also the absence of symptoms two weeks after the occurrence to denote the presence of such a body. A child of barely four years was brought to my study with a history of having swallowed a penny twelve days previously. Being doubtful, I asked the father if anyone saw the penny disappear, and he stated that his wife and mother-in-law were there at the moment, and that they tried to get the coin out of the child's mouth, but could not, and that he immediately became dark in colour from choking. The child vomited five or six times in twenty-four hours for the first few days, but the penny was neither vomited nor passed per *vias naturales*.

I wished to pass a bougie into the œsophagus to solve the problem, but was not allowed. To show how a patient may get accustomed to a foreign body, the vomiting ceased altogether, and the child could eat everything, except that occasionally he complained that pieces of bread or buttered toast hurt him. He was well nourished, being both fat and ruddy. It seemed strange that with such a history he was able to take any solid food he liked, and only sometimes complained.

External palpation revealed nothing, and there was no bulging in the neck.

Judging it to be a most suitable case for the purpose, I resorted to skiagraphy to inform me whether a coin was in the œsophagus or not, and its exact localisation. The accompanying radiogram—for which I am indebted to Messrs. Wyatt and Sunner—shows the coin and its position just behind the cricoid cartilage. Under chloroform, assisted by my friend and colleague, Dr. Welply, I passed a coin-catcher down the gullet, and soon felt a grating, reminding me of sounding for stone in the bladder; with a little difficulty I succeeded in extracting the coin, and the child was running about next day as well as ever, and able to eat its ordinary food.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON.
MEETING HELD MARCH 10TH, 1905.

The President, DR. FREDERICK TAYLOR, in the Chair.

MR. JAMES BERRY showed a case of a man, *æt.* 33, on whom he had performed a rhinoplastic operation for syphilitic necrosis.

A CASE OF ACUTE RHEUMATOID ARTHRITIS.

DR. HALE WHITE read notes of a case of a woman, *æt.* 25, illustrating this disease, and said that it and other cases made him suggest that from among the diseases which are often grouped together under the

joint is frequently implicated and mastication is consequently difficult. Wherever the disposition of surrounding muscles makes it easy to investigate the joints, swelling about them is obvious and the patient usually complains of pain in them. Muscular wasting is so very rapid that it is clearly an extreme degree of genuine arthritic atrophy and not dependent on disuse; the wasting is especially seen in the hand and forearm, but in a bad case it is almost universal. The temperature is often raised daily, mostly in the evening, to a point usually between 100° and 102° F. The hands and feet are often covered with sweat while the rest of the body is quite dry; the patient is pale and the pulse is increased in frequency out of proportion to and apart from pyrexia, although neither from the history nor from the examination of the heart is there any



RADIOGRAM OF DR. REID'S CASE OF FOREIGN BODY IN ŒSOPHAGUS. (See *Clinical Records*.)

names of chronic rheumatoid arthritis, osteo-arthritis, arthritis deformans, and chronic articular rheumatism, there is one which should be sharply separated off as a distinct disease. It has, he believed, the following characteristics: It is usually met with in women whose age is most often near to twenty; the disease begins, or is, at any rate, soon most prominent, in the proximal phalangeal joints, and is quite early strikingly seen in the wrists; it is markedly symmetrical in the two hands, the swelling is considerable and extends beyond the joints so that there is a well-marked fusiform swelling about the affected inter-phalangeal joints and a general swelling about the wrists and other joints; sometimes a creaking may be felt, due apparently to thickening of the synovial membrane. In the course of a very few weeks most of the joints in the body are affected, so that the woman is soon bedridden, unable to move fingers, thumbs, wrists, elbows, shoulders, and the corresponding joints of the lower extremity. The joints of the spine are often affected so that turning in bed is difficult and painful; the temporo-maxillary

evidence to connect the disease with rheumatic fever. Sometimes a number of brown spots like large dark freckles appear on the face, body, and limbs. After two, three, or four, or even six weeks the temperature slowly regains its normal point, the rate of the pulse diminishes, but more slowly than the temperature. The colour partly returns, the sweating of the hands and feet lessens, the pain passes away, but much immobility and some swelling around the joints remain, and the patient is liable to fresh attacks which exactly resemble the first, and result in fresh swelling of and around the already fixed joints. After the acute stage has subsided the sufferer is by no means recovered, for the swelling of the synovial membrane and soft tissues around the joints leads to great immobility of them, and much of the muscular atrophy remains. The patient is hence often a chronic invalid. In this respect, as well as in many others, the disease stands in striking contrast to rheumatic fever. Careful manual examination during life, even in cases which have lasted many years, fails to reveal any lipping or

bony outgrowths in connection with the joints. The deformity appears to be entirely due to effusion into the joint and swelling of the tissues around. Radiographic examination confirms this view. As a rule, the attacks diminish in severity as time goes on and ultimately the patient may only suffer from the deformities due to previous attacks. Dr. Hale White next described the histology of the disease and showed that it undoubtedly originated in the synovial membrane and tissues around the joint, and that no changes occurred in the bone and cartilage except such as might be produced by pressure of thickened synovial fringes. He then described an individual case and pointed out the importance of passive movements in order to prevent fixation. He showed that the bones were unusually transparent to the X-rays, and, lastly, discussed its relation to other diseases, maintaining that it was a distinct disease for which the most convenient appellation would be acute rheumatoid arthritis.

Dr. BERTRAM ABRAHAMS read a paper on

ARTHRITIS DEFORMANS AND ITS ALLIES.

The expression, "arthritis deformans," is selected as the least unscientific of the many names—Putnam in his recent monograph quotes twenty-one—for the disease, and that in most general use on the Continent and in America. There are four chief maladies which are grouped under this head. Of these, that described by Still in children stands entirely apart by reason of its course, the sequence of joints affected, and the associated enlargement of the spleen and lymphatic glands. At the other end of the scale is senile osteo-arthritis, which is a degenerative process that may come on as the terminal phase of arthritis deformans, or quite apart from it as a senile change in normal joints or in those already crippled by true rheumatism. The two remaining affections—acute and chronic arthritis deformans—are, it is suggested, different forms of the same malady, which is in all probability of an infective or at any rate toxæmic nature. In the acute type the poison is in such considerable amount that a large number of joints are, so to speak, flooded with it, and simultaneously affected; in the chronic the intoxication is less severe, but more prolonged, so that the morbid changes are more in the nature of degeneration than of inflammation, and the joints are picked out in a fairly definite order. At the same time, as is only to be expected, much of the brunt of the disease falls upon the nervous system. That the two types merge into one another is further indicated by the number of intermediate forms which are met with. Skiagrams and photographs were shown of the following conditions:—Gonorrhœal arthritis, Charcot's joint, acute arthritis deformans, chronic arthritis deformans, and Still's disease.

Dr. TOOGOOD was very familiar with Dr. Hale White's acute cases, but thought that they were just as commonly met with in men as in women. He remarked on the difficulty in diagnosis between them and gout. In his opinion no drugs were of any avail in the condition. The senile form of the disease, in which fibrillation and other degenerative changes were found in the cartilages, was to be found in nearly all *post-mortems* over sixty. That morning he had examined the joints of a gouty patient which were of this nature; in fact, in his experience, gouty joints always showed these changes. The specimens were exhibited.

Dr. A. E. GARROD welcomed this occasion, for the subject was one that urgently demanded discussion. In addition to the features mentioned by Dr. Abrahams as marking off Still's disease was its comparatively high mortality, whereas the adult cases rarely died. He had found the presence of enlarged spleen and gland to be rarer than Dr. Still originally described. In the adult, leaving on one side the senile complaints, two diseases could be clearly discerned. First, we had Dr. Hale White's acute rheumatoid arthritis, and he would here refer to these cases, which were subacute in their course, progressing steadily for years, and even more disabling than the acute cases. Then there was the multiple osteo-arthritis. This was characterised by a quite different distribution, often implicating the

thumb carpo-metacarpal joint, showed the osteo-phytic changes, and cause far less damage. He suspected the existence of a third condition in which deformity was the prominent feature, this being out of all proportion to the joint enlargement. This deformity could be averted by massage, whereas that due to the other forms could not. There were other cases due to diverse infection, such as the pneumococci, and these caused great difficulty in diagnosis. The confusion that existed was largely due to the infrequency of *post-mortem* examinations. The infection in the rheumatoid cases was very often a puerperal one, this accounting for the frequency of the complaint in women. Grating might be felt distinctly at times, especially in the knees, indicating erosion of the cartilages. Treatment was more efficacious in the osteo-arthritic cases, except in the form seen in single joints.

Dr. A. P. LUFF also thought that several different diseases had been included under the same name. He believed strongly that the infection took place by the alimentary tract, and was convinced of the high value of intestinal antiseptics, notably of carbonate of guaiacol. In the distribution of the lesions he remarked that the acute cases affected the proximal interphalangeal joints, and the chronic the thumb-joints. In the diagnosis between the condition and gout, the two most important points were the symmetry of the former and the sweating or clamminess of the palms and soles. The cervical vertebræ and the temporo-maxillary joint were rarely affected in gout. He commented on the very rapid advances made of late years in the treatment of the conditions. He did not think that the single joint, such as the hip, type of case was of infective origin, but was a traumatic form of osteo-arthritis; monarticular rheumatoid arthritis was therefore a bad term.

Dr. PRESTON KING commented on the advance in knowledge that had occurred as a result of the Cheltenham meeting. Dr. Spender, of Bath, had first pointed out the rapid pulse, the sweating of the palms, and other characteristic features. He did not think that the X-rays were of any value in the diagnosis from gout. That there was a strong nervous factor in the disease was undoubted; it was instanced by the muscular atrophy and the vaso-motor symptoms, such as rapid pulse. He regarded the condition as a result of the action of the rheumatic virus on the nervous system of resistant persons.

M. BLANC, of Aix-les-Bains, related two severe cases that had contracted diphtheria and had been cured of the joint conditions by antitoxin. In ten cases he had used the treatment and improvement had always resulted, with complete cure in two of them. As he rarely had the opportunity of trying its effect apart from bath treatment, he recommended it to those interested as being worthy of further observation. As regards diagnosis, the main difficulty was not in excluding gout, but in distinguishing between the two forms of rheumatoid arthritis.

Dr. WM. EWART was of opinion that the toxic origin of the conditions is now established, though the number of such toxins was legion. The actual poison was more likely to be that secreted by microbes than the microbes themselves, and might indeed be autotoxins. He used the analogy in this connection of the joint changes seen in bronchiectasis. He was at present getting good results by varying the blood supply to the part so as to produce alternate anæmia and hyperæmia.

Dr. LLEWELLYN JONES, of Bath, saw very little difference between the acute and the chronic cases; the temperature ran a similar course in both. Might not the rapid pulse-rate be an indication of a larval form of Graves' disease? This condition was frequently associated; he had seen over twenty such cases, and it was one of the evidences of the close connection between the nervous system and rheumatoid arthritis. In the past year he had seen six cases in which rheumatoid arthritis had followed on gastric ulcer. He referred to various prodromal symptoms, such as local syncopal and asphyxial attacks, cramps, &c. He had been struck by the segmental distribution

of the lesions, thus the ring and little finger were usually affected together, and the thumb and index finger. McCrae had noticed the same thing.

Dr. HALE WHITE, in reply, agreed that the condition he had described was not rare in men. As regards the transparency of the ends of the bones and the fusiform shape of the swelling, he recognised that both occurred in other conditions, but as they were never absent in this disease, their presence or absence was of importance in diagnosis. With regard to the grating observed by Dr. Garrod, he acknowledged that destruction of the cartilage occurred, but emphasised the fact that it was, in these cases, always secondary to the synovial mischief. He was very sceptical as to the power of any drug to disinfect the alimentary canal.

Dr. BERTRAM ABRAHAMS, in reply, agreed with Dr. Luff as to the great value of guaiacol, but could not attribute this to its antiseptic properties, seeing that it was the only member of the group that possessed such beneficial effects. He was interested in M. Blanc's remarks on diphtheria antitoxin, as, ten years ago, he had seen Dr. Sydney Ringer treat several cases with it, and in one case with markedly beneficial results.

ROYAL ACADEMY OF MEDICINE IN IRELAND. SECTION OF SURGERY.

MEETING HELD FRIDAY, FEBRUARY 24TH, 1905.

MR. E. H. BENNETT, F.R.C.S., in the Chair.

EXHIBITS.

MR. L. A. BYRNE exhibited patient after operation for epithelioma of the tongue; also the part removed.

SIR LAMBERT H. ORMSBY exhibited patient whose olecranon had been wired after fracture.

MR. G. JAMESON JOHNSTON exhibited patient who had the power of voluntarily producing a partial dislocation of the knee.

MR. W. I. DE C. WHEELER exhibited an extension apparatus for fractured femur.

MR. BLAYNEY exhibited (a) parts removed in the treatment of acute intussusception, and (b) malignant disease (colloid cancer) of the large intestine.

THE APPLICATION OF PLASTER OF PARIS TO FRACTURED FEMUR FACILITATED BY A NEW APPARATUS.

MR. W. I. DE C. WHEELER exhibited an apparatus designed by himself to facilitate the application of plaster of Paris, either as a primary dressing to fractures of the femur, or at any period before union had taken place, a full description of which we published last week.

MR. E. H. BENNETT was of the opinion that the apparatus was probably useful in general hospital work, but could hardly be used by country practitioners.

MR. TOBIN thought that Mr. Wheeler's method would be useful in the treatment of fractures of the femur in field service.

MR. W. S. HAUGHTON considered the device both simple and efficient. It saved labour, made the subsequent nursing simple, and saved the surgeon paying numerous visits.

MR. KENNEDY also discussed the communication.

MR. WHEELER, in reply, stated that the apparatus was very portable, was by no means difficult to make, and cost about two pounds.

OBLIQUE FRACTURE OF THE TIBIA.

MR. EDWARD H. BENNETT read a paper on this subject, and illustrated his observations by a series of skiagrams. He stated that fracture of the tibial shaft alone was rare as a result of indirect violence, although common enough when the violence acted on the bone directly. Oblique fractures of the central portion of the shaft without accompanying fractures of the fibula are rare. He then related the history of a case which recently came under his notice. The patient, a young girl, *æt.* 15, jumped from a height of about twelve feet on to the ground and immediately fell backwards. Although she was able to stand up she could not put any weight on the injured limb, nor attempt to walk. On being brought to hospital soon afterwards she was

found to be suffering from pain, and complained of loss of power in the limb, but it was not possible to obtain crepitus, nor detect any evidence of abnormal motion in the limb. An X-ray examination, however, revealed the presence of a fracture. It was very oblique, traversing almost four inches of the shaft of the tibia in its middle segment. Its direction was from above and without downwards and inwards. The progress of the case was uneventful, and union was perfect in the ordinary time. The absence of deformity was explained by the integrity of the fibula. The skiagrams obtained from this case afforded the only example he had seen of oblique fracture of the shaft of the tibia only from indirect force.

MR. HAUGHTON expressed himself deeply indebted to Mr. Bennett for the information he had derived from him on the subject of fractures. In studying the long bones stereoscopically one found that the oblique direction of the lamellæ was the rule and not the exception, and that when one regarded fractures from the anatomical standpoint it could be seen that their planes ran parallel to the direction of these bone lamellæ.

The communication was also discussed by Mr. Tobin, Mr. Edward H. Taylor, and Mr. Jameson Johnston.

SOME CASES OF JOINT EXCISION.

MR. KENNEDY read a paper on the above. One case of excision of the knee was remarkable, as the joint was riddled with sinuses, fixed at right angles for years, and the patient showed symptoms of well-marked phthisis, a cavity being present in one lung. Nevertheless recovery quickly followed operation, the lung healing rapidly, and the patient was enabled to get about. In connection with this case Mr. Kennedy dwelt on the importance of fixing the bones together after excision of the knee by Tobin's clamps or by suturing. A case of excision of the shoulder, and one of excision of the elbow, were quoted as examples of dry caries of the articular ends of bones. Although in each the disease was present for years, not a trace of suppuration was present in either. The diagnosis was difficult, and was made clearer by skiagraphy. Mr. Kennedy also quoted the case of a child, *æt.* 4, who had met with an accident producing an epiphyseal separation of the upper end of the humerus. At the operation the articular head was found completely detached from the rest of the epiphysis. The head was removed, and the remainder of the epiphysis sutured to the diaphysis. Complete union followed, although fifteen months had elapsed from the time of the accident to the operation. The child has perfect motion in her arm, and the growth of the limb has not been interfered with.

MR. BENNETT congratulated Mr. Kennedy on the first of his cases—*viz.*, that in which an excision of the knee had been successfully performed in a patient who had symptoms of a phthisical cavity in one lung.

MR. TOBIN had seen some of Mr. Kennedy's cases. The first of these which had just been recorded was one which few would have cared to undertake.

MR. HAUGHTON discussed the diagnosis of early tuberculosis of joints by the aid of X-rays, and gave it as his opinion that a positive diagnosis could be made if the disease had been present for some weeks. Stereoscopy was of great value in these cases. By its aid areas of rarefaction could be discerned, and their true relations to each other and to the joint made out.

In reply, MR. KENNEDY expressed his sense of obligation to Mr. Haughton for his hints as to diagnosis, as cases often cropped up in which it was far from easy to say if bone disease was really present.

Trinity College, Dublin.

The following passed the final in Midwifery at Hilary Term, 1905:—Robert Magill, Michael J. M'Auliffe, George E. Nesbitt, Cecil Scaife, Edward G. Scroope, John A. Pringle, John W. Burns, Joseph W. Houston, Richard Kelly, Robert A. Askins.

The following candidates have passed the final in Surgery at Hilary Term, 1905:—Henry E. M'Cready, Robert Magill, Michael J. M'Auliffe, and Edward G. Scroope.

ASSOCIATION OF MEDICAL DIPLOMATES OF SCOTLAND.

MEETING HELD MARCH 10TH, 1905.

MR. CLAUDE ST. AUBYN FARRER in the Chair.

THE EXCLUSION OF PROVINCIAL QUALIFICATIONS FROM HOSPITAL APPOINTMENTS IN LONDON AND ELSEWHERE.

THE PRESIDENT said that some present no doubt had experienced the disability of not having an English Fellowship, who, in spite of their skill and ability, had been thus debarred from an appointment. Our notice refers to "Disabilities enforced against provincial medical qualifications in many London and some Provincial Hospital Appointments."

"Now, I propose to draw attention to those disabilities with regard to the Scottish colleges. It is a fact that a number of the hospitals in London exclude Fellows of the Scottish colleges from holding appointments in these institutions. In an able article in THE MEDICAL PRESS AND CIRCULAR of March 1st, I read that the Royal Orthopædic Hospital originally did not exclude surgeons from its staff having other than English qualifications. Now according to the amalgamation scheme with the National Orthopædic only surgeons holding a diploma from an English College are admitted. This to my mind is a great injustice and why, I ask, should these things exist? Who is responsible for it? What have the Hospital Funds to say on that point? Is it contended that the examinations for the excluded diplomas are inferior in scope or severity as compared with the corresponding ones of the English colleges? Look at the syllabuses and compare them; they are similar. Again look at those holding these diplomas and who are fortunate enough to hold hospital appointments in London. In my humble opinion, and as far as I am able to judge, and I could name many, even some who are amongst us to-night, whose knowledge and skill and sound judgment would certainly eclipse others who, sometimes, are simply chosen because they have the English Fellowship. It seems to me that no examination or series of examinations beyond a certain stage can be a gauge of a man's capabilities. It is the man himself who ought to be chosen for these appointments, provided he has, say, a Fellowship of his college. Some men are good at passing examinations, but in other respects may be failures. Able physicians and surgeons are born not made by examinations. Let these able men who have proved themselves as such be elected irrespective of college (English or Scottish) or creed. The hospitals and the public will be the gainers by this arrangement. Why should the portals of some of our hospitals be closed against capable qualified men? Does not this savour of monopoly? Are not the hospitals supported and the Funds derived from all, irrespective of country? The management committee does not say only English may subscribe. Have not others given largely and generously to the help and support of these splendid institutions? The hospitals in the provinces are, I believe, as great or greater sinners in this respect than London, but possibly they take their cue from London, and follow suit only in a greater degree. I think you will agree that this evil (shall I call it?) exists. I have given a typical instance of recent date; only one out of numbers it is true, but sufficient for my purpose. Now as to the remedy or remedies, I hope that in the papers and discussions to follow some practical way may be pointed out these wrongs may be righted."

Dr. HARDYMAN (Bath) congratulated the Association on having, at their first meeting, taken up the important subject of the disabilities of medical diplomates of Scotland and Irish diplomates in the hospitals of England. An ounce of fact was worth a ton of theory. He would therefore read some illustrative rules:—

"Every candidate for the office of honorary assistant physician shall be a graduate of medicine of one of the Universities of Great Britain or Ireland, and every candidate for the office of honorary assistant surgeon shall hold the diploma of M.R.C.S. England." Why?

"The resident medical officer shall hold the conjoint diploma of the M.R.C.S.Eng. and L.R.C.P. London, or be a graduate in medicine of a University of Great Britain or Ireland. The house surgeon shall hold the diploma of M.R.C.S.Eng." Why?

Again. "Every honorary physician shall be a graduate in medicine of one of the Universities of Great Britain or Ireland and a Fellow or Member of a British or Irish College of Physicians, and every honorary surgeon shall be a Fellow by Examination of a British or Irish College of Surgeons, but in the event of a candidate not possessing in the former case a Fellowship or Membership of a College of Physicians, or in the latter case a Fellowship of a College of Surgeons, an engagement on his part to obtain the same in each instance respectively, within two years from the date of his appointment, shall be accepted."

Now these rules cut out Scottish and Irish diplomates from a public institution, when such restrictions might prevent the best local men from being appointed. In this same town there is another hospital, older and larger, with three honorary physicians and three surgeons where the appointments are open. Out of these six, four hold Scottish diplomas and the previous senior physician held an Irish one. In the former hospital above mentioned, it might be said that the hon. surgeon may hold office through the F.R.C.S.Ed., and that it does not say that he requires to be a M.R.C.S.Eng., but an assistant surgeon is always chosen, and that by seniority, to hold the office of hon. surgeon. What is the cause of this ostracism? Is it that our diplomas are so poor that they cannot compare with the English diplomas? or that the Scottish training produces men too good to be competed with on equal professional terms? If it is the former there is surely no need to fear competition—if the latter, then they do the hospitals a grievous injury. Who keep out the Scottish diplomates? They are the English diplomates and not the lay members of the hospital committees. In the Scottish hospitals the English diplomates are welcomed if they are good enough in other ways for appointment. How were our grievances to be remedied? We must be united and hold high scientific and ethical ideals. We must get all the might and authority we can on our side through our colleges and Universities. There were many rocks ahead, one being that the hospital appointments are in the hands of different committees all over the country, who are difficult to appeal to and still more difficult to impress with the justice of our cause because they naturally turned to their professional staff for advice. These committees have to be fought *seriatim*.

Dr. DAVID WALSH said that the disabilities attached to certain medical qualifications in the tenure of many hospital appointments was a grievance of old standing. Medical men were realising the importance of self-government. At present medical men are at the mercy of a General Medical Council and of a number of qualifying corporations, all more or less absolutely autocratic and careless of the general interests of medical men. The subject of hospital disabilities had been systematically dealt with by the Irish Graduates' Association, founded about 1878 or 1879 with James Thomson, of Leamington, as Honorary Secretary. The name of the Society was changed in 1885 to that of the Irish Medical Schools' and Graduates' Association. On June 21st, 1888, on the proposition of the President, Professor MacAlister, F.R.S., seconded by Sir George Paget, K.C.B., a statement was ordered to be printed for circulation among lay governors of hospitals, setting forth the arguments against such limitation. On March 17th, 1889, Dr. Macnaughton-Jones, the then president, stated that they "had done much to remove the prejudices and the disabilities for hospital appointments which exist against Irish graduates in England." It was the aim of the Scotch Diplomates' Association to gain equal treatment for Scotch qualifications in every part of the United Kingdom. In 1890 Mr. James Stewart, of Clifton, stated that these disabilities against Irish and Scotch diplomates were enforced in sixty-eight

large public hospitals and infirmaries in England. Also that under a similar condition the then Director-General of the Royal Navy would have been ineligible. At that time there were 486 Irish diplomates in London. At the present moment there were 830 Scotch diplomates in the metropolis. A serious permanent disability, therefore, is inflicted upon some 1,200 medical men in London alone. The essence of the position was that exclusion of outside diplomates from hospital appointments enhances the value of the diplomas of the London Royal Colleges. The provincial diplomates were therefore ousted from a fair chance of reaching the top of the tree, or at any rate they were enormously handicapped in a London career by being excluded from the large hospitals. The London colleges had by exclusion enhanced the value of their qualifications, for which they already charged exorbitant fees. The traditions and management of the London colleges savoured of mediæval class privilege and were absolutely out of touch with such leading principles of modern thought as those which insisted upon equality of opportunity for all men and upon government by consent of the majority. Of all the mediæval survivals still clinging to the London colleges there was none more offensive and grotesque than that which excluded the diplomates of rival colleges from the great hospitals of the metropolis. The first step towards a remedy was publicity of the facts of the case, as for instance by circularising governors of hospitals. The General Medical Council had declined to act in the matter. The colleges of the excluded diplomates, however, might enter standing protests. Money, of course, was needed to cover the expenses of organisation. Pressure, too, should be brought upon the Metropolitan Hospital Funds. Quite recently an audacious attempt had been made to make two of those Funds catspaws in extending hospital disabilities to two hitherto open institutions. The standards of the London colleges were not necessarily the highest and the most successful in turning out able and original men. The fellowship of the London Physicians was an honorary qualification, conferred upon many young and unknown men but withheld from the late Dr. MacLagan, who had introduced the salicylates in the treatment of rheumatism. The *Register* alone should be a sufficient qualification for hospital service.

Mr. J. LENNANE remarked that there was no need to make invidious comparisons as to the relative value of London and provincial qualifications. The exclusion of Scotch and Irish diplomates was not settled on that score. The essence of the thing was that no Scotch or Irish need apply.

Dr. MACNAUGHTON-JONES, speaking as one of the visitors, and also as a Fellow of the Edinburgh College of Surgeons, said that for years the Irish Medical Schools' and Graduates' Association had taken the matter up, with the assistance of men like Prof. Gerald Yeo and the late Sir Thomas Crawford, with other distinguished Irish diplomates. They had so far succeeded that at three annual meetings of the British Medical Association this monopoly of hospital appointments was condemned, first at Dublin, next at Glasgow, and again at Bournemouth. At Bristol, at the East Sussex Hospital, and at Tunbridge Wells this disability rule had been rescinded. The Association had also sent a statement to the governors of all the principal hospitals in England and Wales, and had endeavoured to arouse the active interest of the Royal Colleges of Ireland. This exclusive condition might be looked at from three points of view: Its effects on the interest of the State, its effects on the public at large, and, lastly, on the medical profession. It could not be for the good of the State to hamper progress by placing a drag on ability, and robbing its servants of opportunity. Opportunity makes many men, but it is given to few men to make opportunity! Hospitals were often the sole opportunities of surgeons. Deprive them of these, and you take from them their only chances of arriving at distinction and eminence. Thus the State is deprived of an unknown quantity of able men, and the possibilities which only now and

then arise from the gift of genius. As to the public and the sick poor, for whom hospitals were intended, what must be their loss by the shutting out from all competition of a large proportion of the medical profession? If we looked to the public services, we should find that the highest posts in these were frequently held by Scotchmen and Irishmen. A late Director-General of the Navy was an Irish diplomat, and before his time it had been held by a Scotchman—Sir James Reid. The present Director-General of the Army Medical Service and the heads of the Indian Medical and Netley Departments were Irish graduates. The most brilliant modern work in medicine and surgery had come from Scotland and Ireland. There were at the present moment in Scotland some of the most famous and illustrious of living surgeons. Were they to be told that those holding the highest qualifications of the Scotch and Irish colleges were incompetent to fill the position of surgeon to an English hospital? If not, then on what ground, save that of a jealous monopoly, were diplomates of these colleges boycotted in the English hospitals?

Dr. FITZGERALD POWELL said the *locus standi* of the London colleges was that their standards of examination were higher than those of the outside colleges. The public were certainly informed to that effect. The question was, therefore, how were the public to be put in possession of the real facts of the case? They must appeal to the Scotch and Irish colleges and ask them to make it known if their standards were equal to those of London, and, if not, to make them equal.

Dr. HERSHELL remarked that the real reason of the exclusion of certain qualifications was that a London hospital appointment was the only avenue to lucrative consulting practice. To exclude Scotch and Irish diplomates was to exclude two-thirds of the effective competition.

Mr. CANNY RYALL narrated some personal experiences of the injustice inflicted by the excluding regulations. As a teacher he maintained a man could pass the English Fellowship examination in anatomy without having dissected a body.

The following resolution was proposed by Dr. HARDYMAN, seconded by Dr. FITZGERALD POWELL, and carried unanimously:—"That this Association of Medical Diplomates of Scotland records its regret that so many English public hospitals have still among their regulations a rule the effect of which is to exclude from candidature for honorary appointments on the staff all who do not hold the diploma of two specially favoured London colleges, and that this Association pledges itself to do all that lies in its power to remove this injustice."

Mr. SYDNEY STEPHENSON asked what was to be done to give force to the resolution. After some discussion, he proposed a resolution, seconded by Dr. S. LIGHTFOOT, and unanimously adopted, that a copy of the former resolution be sent to hospital secretaries and chairmen concerned throughout the Kingdom, and to the Hospital Funds.

The meeting then terminated.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

MEETING HELD THURSDAY, MARCH 9TH, 1905.
JOHN TWEEDY, P.R.C.S., President, in the Chair.

CLINICAL EVENING.

Mr. EDGAR CHATTERTON showed a woman, æt. 38, who had the inner canthi, caruncles and innermost extremity of the lower palpebral conjunctivæ discoloured and of a dark grey appearance. As far as she knew this appearance had always been present. She had never had her lids treated with anything, neither had she any sign of old disease. Her occupation consisted of filling toy crackers with fulminate of silver and she had done this work for years. Mr. Chatterton suggested that the silver salt had got into the eye and had caused the discoloration shown.

Mr. CHARLES BLAIR showed a case of "Retinitis

Proliferans" in a woman, *æt.* 59. The vision of the left eye was suddenly lost six months ago. The right fundus showed changes suggestive of albuminuria with numerous retinal hemorrhages. The urine was, however, free from both albumin and sugar.

Mr. A. OGILVY exhibited a most interesting case of "Pemphigus of the Conjunctiva" occurring in a farm labourer, who, for failing health, went to Canada. Shortly after getting there he suffered from pemphigus, the attack lasting for six weeks. He remained well for six weeks and then returned to England at which time he could see to read with ease. On the passage home he had another attack which was very severe. The eyes got rapidly worse and now the corneae were seen to be opaque and the conjunctiva was so shrunken that but little sac remained and the entropion was most troublesome. Lanoline applied to the eyes gave great relief.

Messrs. LAWSON and PARSONS showed a drawing of a case of Sarcoma of the Choroid which occurred in a man, *æt.* 34. He had had a squint for two years and the sight of the right eye had been failing for a year, and when first seen it was almost blind. For 3 months a black swelling has been present on the sclerotic and this was increasing rapidly in size, and had much the appearance of a staphyloma. The eye was blind and the lens was opaque. The eye was removed and on section a large sarcoma was found which was thin and flat and not at all like the choroidal sarcoma that is commonly seen.

Mr. PARSONS gave a lantern demonstration of some cases in which peculiar folds in the retina were found in certain eyes that had been examined pathologically.

Mr. HALLIBURTON McMULLEN showed a child, *æt.* 9 months, who was brought on account of an occasional upward deviation of the eye which had been noticed directly after birth. On examination it was found that there was complete absence of downward rotation of the right eye, the movements in other directions were normal. On looking downwards the left eye fixed, while the right eye was rotated upwards and outwards and was slightly retracted, the eyelid at the same time became elevated and retracted. The inferior rectus and possibly also the superior oblique, was defective.

Mr. R. E. BICKERTON showed a case of Peculiar Changes in the Optic Disc, Retina and Choroid occurring in a patient *æt.* 15. When first seen in July last, he had well-marked neuritis in the right eye with surrounding retinitis. The disc was now raised, it was of a bluish-white colour and had a wool-like margin. There were also numerous fundus changes which were beautifully illustrated by ophthalmoscopic drawings.

Mr. CHARLES WRAY showed a man who had improved considerably while under his treatment for tobacco amblyopia. This treatment he fully described at the last meeting of the Society. It consisted briefly of making such patients take brisk walks and drink large quantities of water.

Messrs. ORMOND and McCASH showed a man who had a piece of metal embedded in the retina.

Mr. R. R. CRUISE showed a patient from whose eye he had extracted a piece of metal with Haab's magnet, and in which some interesting fundus changes were present.

ULSTER MEDICAL SOCIETY.

MEETING HELD IN THE PATHOLOGICAL LABORATORY, QUEEN'S COLLEGE, THURSDAY, MARCH 2ND.

The PRESIDENT (DR. WM. CALWELL) in the Chair.

IN opening the proceedings reference was made to the fact that this annual "laboratory meeting" was held just at the right time to welcome Professor Symmers, who had arrived from Cairo only a day or two before, to take up the duties of the Professorship of Pathology.

Professor SYMINGTON and Dr. HANNA showed several anatomical specimens, including a fine set of young

temporal bones to show the development of the air cells, and some greatly enlarged photographs of the internal ear.

Professor T. H. MILROY read a short paper on "The Exchange of Nutritive Material between Different Organs of the Body, as Exemplified in the Spawning of Fish." The paper, which was exceedingly interesting, was the outcome of an inquiry into the spawning of salmon and herring, made by Professor Milroy at the request of the Scottish Fisheries Board. As is well known, the salmon takes no food after leaving the salt water, and when the ovaries enlarge, they must do so at the expense of other organs. Professor Milroy has shown that the necessary fat is got from various muscles in the fish, but never from those needed for its propulsion. After the expulsion of the ova, the fish begins to improve in condition, and this though it is still not feeding, which change he proved to be due to the assimilation of the degenerating tissue in the ovary, and its reconversion into muscle. The great interest of these observations lies in the fact that in them we can see the interchange of material between different organs, uncomplicated by the addition of nutrient material from without.

Dr. J. A. MILROY gave a microscopic demonstration of some specimens illustrating the structure of the ductless glands.

Dr. R. L. GRAHAM described a case of General Paralysis of the Insane with Meningo-Myelitis, and illustrated his description with a large number of very fine micro-photographs which he had done of vertical and transverse sections of the cord.

Professor BYERS showed a number of specimens of uterine and ovarian tumours, and a series of plaster casts of the foetal head, which he had just obtained from Berlin.

Dr. JOHN CAMPBELL also showed several specimens of similar tumours.

Dr. ST. GEORGE showed two tumours, one a parotid, and the other an axillary tumour. Of these, as well as of many of the other tumours shown, Dr. Wm. Mair showed microscopic sections.

Dr. H. L. MCKISACK showed a ruptured aneurysm of the basilar artery.

Mr. MITCHELL showed several tumours, with sections.

Mr. FULLERTON exhibited a stomach showing gastric ulcer with erosion of the pancreas.

Dr. JAMES LYNASS exhibited charts showing the effects of the serum treatment of erysipelas.

Dr. MARION ANDREWS showed an abscess of the ovary, and also a series of specimens preserved and mounted by the Kaiserling method, the advantage of which is that it preserves the natural colour of the specimen as when it comes from the operating theatre or *post-mortem* room.

Dr. THOMAS CARNWATH read a note on the Value of the Streptococcus as an Index of Sewage Contamination. This was one of the most interesting items on the agenda paper, as Dr. Carnwath imparted "local colour" to his communication by a most lucid account of his experiments with Belfast sewage, illustrating it with a map of the Lough into which the sewage is discharged, and charts showing the varying quantities of streptococci found at different points in it. As the question of the pollution of the shores of the Lough is very much to the fore of late, the paper was listened to with special interest.

Dr. THOMAS HOUSTON demonstrated the method of preparing and administering a vaccine for the treatment of staphylococcal lesions (A. E. Wright's method), and he and Dr. J. C. RANKIN showed preparations demonstrating that the opsonic power of the serum is destroyed by heat at 60 degrees.

At the last meeting of the Society, Dr. Houston showed several cases treated with great success by this method, so that the scientific account of the method and the demonstration of its working were looked forward to with much interest, which was fully justified by the event.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, March 12th, 1905.

INDICATIONS AND COUNTER INDICATIONS FOR THORACENTESIS.

WHEN should thoracentesis be practised in cases of serous effusion, and when should the surgeon abstain from it?

Thoracentesis is indicated, says Schlesinger, firstly when there is danger of death. The grave signs are continued, syncope, thready pulse, cyanosis of the skin and mucous membranes, turgescence of the veins of the neck, deviation of the heart. Secondly, when it is impossible to cure the malady otherwise. If the effusion remains for weeks without tendency to diminish in spite of medical treatment, the operation is imperative. As a general rule thoracentesis should not be practised before the third week and as long as fever exists unless there arises some absolute indication for interference. An operation practised during the febrile stage of pleurisy only gives temporary relief, for the effusion returns. Yet at the end of some days, even if the fever persists and the exudation progresses, tapping cannot be avoided and frequently it has to be repeated. The best chance of success is obtained, however, when the fever has abated, the effusion is stationary and the urinary secretion has diminished.

In hæmorrhagic pleuritis, the operation has sometimes to be repeated frequently. Malignant tumour of the pleura gives rise to considerable effusion, producing intense dyspnoea.

As to accidents, they are only the result of imprudence. Death can follow immediately after the tapping, especially if a large quantity of liquid is removed at once (over three pints); the operation should be done slowly, guided by the dyspnoea of the patient. Death is due to embolus derived from thrombus of the pulmonary veins, and it can be caused by phenomenal cerebral anæmia.

Traumatic pneumothorax is frequently observed after thoracentesis, although not always recognised, but may disappear in three or four days without provoking any alarming symptoms. Sometimes, the patient expectorates a clear, albuminous liquid after the operation.

The canal of the puncture rarely becomes fistulous, and when performed aseptically the serous liquid will not become purulent.

TREATMENT OF FLATULENCE.

Peroxide of magnesium, 6 grs.

For one wafer to be taken half an hour before each meal.

After meals, the following powder:—

- Prepared chalk, 15 grs.;
- Bicarb. of soda, 8 grs.;
- Calcined magnesia, 8 grs.

In case of burning sensation in the stomach and pyrosis:—

- Prepared chalk, 15 grs.;
- Subnitrate of bismuth, 6 grs.;
- Calcined magnesia, 12 grs.;
- Codeine, $\frac{1}{4}$ gr.;
- Powdered belladonna, $\frac{1}{4}$ gr.

For one powder.

Preparations of naphthol should be avoided, as they irritate the stomach.

DIARRHŒA OF CONSUMPTIVE PATIENTS.

- Methylene blue, 3 grs.
- Lactose, 20 grs.

For one wafer, to be given daily.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, March 12th, 1905.

At the Society of Charité Physicians, Hr. Lazarus showed a case of

FRIGHT PARALYSIS,

in which recovery took place in three weeks. After electrification the sensibility returned suddenly over the whole body. Power of movement soon returned after

paradisation of the extremities, and shortly after the power of voluntary movement.

Hr. Greef related a case of

EXTIRPATION OF A RETROBULBAR TUMOUR WITH RETENTION OF THE BULB.

The patient remarked six years ago that one eye was more pronounced than the other. As he declined operation, potassium iodide was given but without result. Some loss of visual power came on, however, so that he returned for further treatment. It was then ascertained that the right eye projected 1.6 cm., the left 2.9. Besides this, the eye was twisted a little outwards and downwards. Vision was reduced to $\frac{1}{4}$, and the field was somewhat limited. There was venous hyperæmia at the fundus. The case was taken to be one of tumour springing from the orbital periosteum. The patient was willing to submit to operation on the condition that the eye itself should be spared. The tumour was removed by dividing the internal rectus muscle and turning the eye out. After the operation the eye was blinded and there was slight ptosis. The tumour proved to be a sarcoma.

He also related a case of

CARCINOMA OF THE EYE-LID WITH RECOVERY BY RÖNTGEN RAYS.

The patient was a man, æt. 61, who had an ulcer on the eyelid that was rapidly destroying it. After extirpation of the bulb, the diagnosis of carcinoma was confirmed, the ulcer was treated by Röntgen light, and recovery rapidly took place.

Hr. Thörner spoke on

OPERATIONS FOR MYOPIA.

He did not seem very much in favour of operative interference. In addition to the known danger of infection there was the risk of separation of the retina and creeping irido-cyclitis. Out of 17 cases operated on, the bulb was destroyed 8 times; in 9 cases the operation did well, vision became sufficiently good, but later on there was enlargement of the image before the eye that had been operated on. The limits for a possible operation were up to the dioptries.

Hr. Greef was of opinion that the operation should be abandoned.

Hr. Wiesener spoke on the

TREATMENT OF TRACHOMA,

the medicinal, mechanical, and the operative. The first consisted in the employment of nitrate of silver or sulphate of copper; the mechanical in rubbing of the conjunctiva with lint soaked in sublimate solution or in scrubbing off with a brush; the operative in destruction of the granules on the conjunctiva. The results of recent treatment with Röntgen and radium rays were problematical.

Hr. Greef was in favour of the mechanical treatment.

The *Deutsch. med. Woch.* has a note on the

USE OF SALICYLATE OF SODA AS A GARGLE.

Six grammes of salicylate are dissolved in 120 of water. A tablespoonful of iron solution is used as a gargle in half a glass of warm water. In violent inflammatory affections the gargle should be used hourly. The pain in swallowing is said to quickly diminish on using the gargle. The anæsthetising effect of the gargle shows itself on the mucous surface of the pharynx as well as of that of the mouth and gums. A dressing soaked in a 5 per cent. solution rapidly relieved the pain of ulcerating chilblains and brought about recovery. In angina with white muco-purulent deposit and in pseudo-diphtheria, the pseudo-membranes disappeared in two or three days. In such cases, however, the salicylate should not be stopped too soon, or the membrane would return. The writer had employed the treatment frequently among the students of the Kriegsschule from 13 to 18 years of age. They came complaining of feeling unwell with temperature varying from 38-39-40; he ordered gargles of salicylate to be used three or four times before they retired to their dormitory. The next morning the temperature was 37° C., and the patients cured. It was an excellent disinfectant wherever used.

At the meeting of the Charité on the 13th ult. Hr. Federmann related a case of

SPLenic ABSCESS WITH OPERATION AND RECOVERY.

The patient was a man recovering from typhoid fever. Leucocytosis had been determined before the commencement of the fever. When the fever had subsided the temperature went up again, and dulness was noticed over the thorax to the left and behind. The speaker found pus in the pleural cavity, resected a rib, and then saw the diaphragm bulging strongly. After he had determined by exploration puncture that there was pus, he incised, when brownish pus came out from a subphrenic abscess. In it were floating pieces of necrosed spleen which were removed. After the fever had existed for eight weeks, the parts healed without a fistula. He considered that the leucocytosis marked the existence of a complicating suppuration.

Hr. Federmann also spoke on the

TREATMENT OF ACUTE PERITONITIS BY HORSE SERUM.

The fact that peritonitis was generally a mixed infection made it unlikely that any specific serum would be obtainable. It would be better to strive to excite a hyperleucocytosis, and in this way to heighten the resistance power of the organism. Horse serum was suitable for such a purpose. This possessed bactericidal properties in a high degree, but this property was mostly destroyed by heating.

He had hitherto used sterilised serum, *i.e.*, serum that had been heated, in 11 cases. The results had not been very encouraging, whether the serum had been injected or introduced into the peritoneum, but he hoped by means of a sterilised serum that had not been heated to be able to obtain better results.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, March 12th, 1905.

HEMANGIOMA VENOSUM CAPITIS.

At the Gesellschaft, Eiselsberg presented a young woman on whom he had operated for a hæmangioma on the head. The patient was *æt.* 17, and from birth had a swelling over the right parietal bone, appearing in the middle line, if history can be trusted. The growth was soft and fluctuating when pressed, and could be moved from its position on the cranium, in which a deep indentation could be felt, which the tumour had produced by long contact with the bone.

The exploring needle revealed nothing but blood, which led to a diagnosis of sinocele, according to the classification of Hæker and Lannelongue, and which Churciens later designated pericranial hæmangioma. After the tumour was removed the diagnosis was confirmed by microscopic examination. The literature of the subject records sixteen cases of this rare affection, observed by Chipault in 1897.

HYPEROSTOSIS OF THE CRANIUM.

Ranzi showed a young woman from whom he had removed a large osteoid tumour about the size of a child's head. It was situated on the left side of the frontal bone and extended along the parietal bone on the same side. The history of its growth seems to have commenced about the fifth month, which at this time appears to have been about the size of a hen's egg over the supra-orbital region. Within the last two years a severe form of exophthalmos appeared with a congested form of the fundus of the eye. After removing the tumour the exophthalmos and congested papillæ disappeared completely, and the wound healed without any untoward circumstances.

SYPHILITIC VACCINATION OF THE CHIMPANZEE.

Kraus gave a record of his experiments in transmitting syphilis to the macacus. He prefaced his remarks with a history of the subject, and thought that Metchnikoff and Roux were the first who succeeded in proving that the syphilitic virus could not be transmitted in the chimpanzee. In support of this conclusion he could now add his personal testimony in its favour after two years' experiments on the macacus. In the anthropoid the primary effects cannot be exhibited, although a localised induration can be effected at the point of insertion, but the general effects are

absent. This sclerosis with secondary papules were observed by Mracek, which he compared with the human sequelæ, but his own observations were that sclerosis in healthy macacus did not appear, and that no incubation period of eighteen or twenty days could be observed, as had been recorded to be typical of the ape. This local hardening seemed to become feebler on every transmission, and it soon disappeared altogether. At this point he showed the sclerosis on a cynocephalic baboon, but no general symptoms had appeared. It had one common symptom with the human sclerosis, which was a tendency to destroy the surroundings.

Neumann said that this was still a debatable question as he could recollect many experimenters during the last century, many of whose results were negative, although a few were confidently affirmed to be positive. For his own part he had to confess that his experiments in 1882 were negative, although those conducted on guinea-pigs exhibited the venereal sores with lymphatic inflammations. He confessed that Metchnikoff, Roux, &c., were the first investigators to put experiments on a scientific basis. Notwithstanding all these negative results syphilis is not solely confined to the human race, as many other animals can be affected. No antitoxic serum can be discovered.

SARCOCELE SYPHILITICA DEXTRA.

Ehrmann exhibited a patient with a sarcocele resembling cancer, which he pointed out could hardly be cancerous, chondromatous or sarcomatous. The glands in the neck and groin were greatly enlarged, and five years ago there seemed to be a history of ulcers on the leg. In September last year the patient complained of alimentary disturbance, such as loss of appetite, vomiting, icterus, and pronounced emaciation. No anti-syphilitic treatment seems to have been prescribed, although the exanthemata indicated late syphilitic grouping. The regular smooth surface of the scrotum was against cancer, chondroma or sarcoma, while the glands of the neck and abdomen were in favour of syphilis. He diagnosed the case as a general infiltration of the fibrous tissue of the scrotum, and therefore indicated syphilitic treatment.

ADRENALIN AND ARTERIO-SCLEROSIS.

Braun next recorded the results of his experiments at the Paltauf Institute, where the question had been asked if intravenous injections of adrenalin produced arterio-sclerosis. His experiments had been largely conducted on guinea-pigs with amyl nitrite. His results pointed to a toxic genesis in the arterial system which produced increased pressure associated with the vascular changes. He pointed out that the therapeutic treatment in reducing the pressure in such sclerosis was only treating the symptom and not the disease itself.

Hungary.

[FROM OUR OWN CORRESPONDENT.]

BUDA PEST, March 12th, 1905.

At the recent meeting of the Budapest Royal Medical Society

Dr. Rác read a paper on

AORTIC INSUFFICIENCY AFTER TRAUMA.

Severe injury may result from the rupture of an aortic valve where atheroma is present, but it is less commonly known that the same may occur in perfectly healthy valves. Aortic insufficiency follows, but extensive vegetation at the tear may also narrow the orifice. It is generally found that an exceedingly loud and rough murmur speaks for a traumatic etiology in doubtful cases, but this is not always so, according to Dr. Rác, who gave the detailed history of a case with a very definite murmur. Sometimes on auscultation, no murmur can be heard at all.

Dr. Lakatos exhibited a case of

SYPHILITIC POLYARTHRITIS.

The patient dates the primary lesion to five years ago. The course of the disease did not seem to be typical,

although the diagnosis is undoubted. A few months before admission to the hospital sudden pain appeared in the left great toe and in the left sole; the next day the pain spread into the ankle of the same side, and in a week the knee-joint was attacked. The pains were especially aggravated at night. Later on the right knee was invaded. Treatment for chronic articular rheumatism, though energetically applied for a long time, failed to produce any results. The epiphyseal ends of the bones at the attacked joints were markedly thickened and tender to pressure. Patient walks with difficulty and pain; is hardly able to flex his knees, and is entirely unable to extend them. Passive movements elicit crepitation. Left shoulder-joint appears to be thicker than the right, and abduction is limited to 45 degrees. The muscles of several joints were markedly atrophied. Rheumatic affection could be excluded in view of the chronic course of the disease, the nocturnal exacerbation of the pains, the absence of any marked alterations in the skin over the affected joints, as well as of any febrile condition during the whole length of the attack, and finally the complete failure attendant on energetic anti-rheumatic treatment. Tuberculosis of the joints was excluded by the multiplicity of the affected joints, by the fact that no purulent exudations were detected in any of the joints, the low temperature and the absence of tuberculous signs anywhere in the system. As a matter of fact the employment of iodide of potassium in conjunction with mercurial ointments improved the condition rapidly and radically. After a series of injections the patient began to feel better, gained 23 pounds in weight and walked with comparative ease. The author is inclined to consider this polyarthritis as belonging to a late period of syphilitic manifestations. The patient very likely entered the hospital at the period of transition from the secondary to the tertiary stage; and it was because of this that the mercurial treatment in conjunction with iodine was more effective than the iodine alone, as employed in the beginning.

Dr. Adolf Erdős (Nagyvarad) read a paper on.
**ANTISTREPTOCOCCUS SERUM IN ERYSIPELAS AND
 PUERPERAL SEPSIS.**

The results of the employment of anti-streptococcus serum published so far are so contradictory that no definite idea can be formed as to its utility as a therapeutic agent. Dr. Erdős presented two cases of erysipelas and two cases of puerperal sepsis, in which he used the serum. The first was a typical case of facial erysipelas in a woman, *æt.* 50. The disease was in its fifth day of development, spreading rapidly and unyielding to various remedial agencies such as carbolic acid, ichthyol, &c. When 20 c.cm. of antistreptococcus serum were injected, improvement followed the next day, and in the course of a week the patient was rapidly convalescent. In the second case the favourable results of the injection manifested themselves on the third day. Of the puerperal cases the first became septic soon after delivery; when seen by the physician, during the third week after confinement, she presented typical signs of sepsis, pain in the uterus, daily sweating, offensive lochial discharge, abdomen somewhat distended and very painful; 20 c.cm. of the antistreptococcus serum were injected, followed on the next day by a double dose; improvement was gradual, but undoubted, and in the course of a month the patient was discharged well. In the second case, that of an adherent placenta that necessitated extraction, sepsis was quite pronounced during two weeks, at the end of which an injection of the serum was made; but as improvement was not observed, and the supply of the serum was exhausted, routine treatment was resorted to, until a new supply of the serum was injected on the fifth day. Unfortunately, the results of the treatment became obscured through an unexpected complication of pneumonia. However, the patient eventually recovered with a somewhat diminished mobility of the uterus. Notwithstanding the small number of cases in which the serum was employed, the results obtained are undoubtedly interesting, and may lead to further trials.

Operating Theatres.

NORTH-WEST LONDON HOSPITAL.

REMOVAL OF A LARGE VESICAL CALCULUS.—Mr. MAYO COLLIER operated on a man, *æt.* 43, the subject of calculus of the bladder. The patient had complained in the last few months of frequency of micturition accompanied by pain before, during, and after micturition. The man had previously sought advice at a hospital three months ago, saying then that he had caught a chill, and complaining of the same symptoms but in a mitigated form. The ordinary remedies for cystitis were at that time administered with considerable abatement of symptoms and corresponding comfort to the patient. This improvement, however, was not permanent, and the case was admitted into the hospital under the care of Mr. Mayo Collier. The patient was a pale, thin, badly-developed individual; he was a house painter by trade. There was no evidence of gout or of over-use of alcohol. The heart and lungs were apparently healthy, and nothing abnormal was discovered in the abdominal viscera beyond the trouble in the bladder. A diagnosis of stone had previously been made in the out-patient room. Mr. Collier said that on admission he did not pass a sound to confirm the diagnosis on account of the extreme irritability of the bladder. The patient having been placed under an anæsthetic, a small sound was introduced into the urethra, but its introduction to the bladder could not be accomplished without some difficulty. The beak of the sound on its entrance to the bladder immediately encountered a stone whose presence was audible to all the bystanders. With difficulty the sound could be introduced some two or three inches during which the grating of the stone was never absent. Mr. Collier remarked that he believed that this was a very large stone, and decided on performing the suprapubic operation. An incision some three inches in extent was made in the middle line above the pubes (after the bladder had been injected with some four or five ounces of fluid); the recti being retracted, the pericyclic fat was easily exposed, and the outer wall of the bladder reached. On the introduction of the scalpel into the bladder, its point struck a stone immediately under the mucous membrane of the viscus. It was now found that the bladder was extremely small, much thickened, and was almost completely filled by a hard, very large calculus. The opening into the bladder was enlarged as much as possible, and an attempt made to introduce the finger so as to free the stone from its surroundings. By the introduction of a pair of ovum forceps the stone could not be lifted from its bed. Mr. Collier directed his assistant to pass his finger into the rectum and endeavour to raise the stone into the opening of the wound so as to enable him to shell it out with the assistance of a rough elevator. After some considerable trouble the calculus was extracted, and proved to be a hard uric acid stone having much the size and appearance of a large potato; some scales and spicules that were detached during the manipulations were removed and a large drain inserted. Mr. Collier said this was one of the largest stones (its weight 3.025 grains, or nearly 7 ozs., its longest diameter nearly 4 ins.) he had seen removed from a bladder; and it was remarkable, he thought, that this patient could have got about with the few symptoms he had

complained of. That it must have existed for some time was presumable from the fact of the extreme contraction and thickening of the bladder. The chief difficulty in its removal, he remarked, was due to the limited opening at his disposal, but by careful dilatation and stretching the parts the stone was ultimately delivered without much damage to the surrounding tissues.

In spite of an extremely critical condition of heart failure and hypostatic congestion of both lungs following the operation, the patient has rallied, and a fortnight after the operation is advancing toward convalescence.

TOTTENHAM HOSPITAL.

UNUSUAL CAUSE FOR RECTAL HÆMORRHAGE IN A BOY.—Mr. H. W. CARSON operated on a boy, æt. 11, who had been admitted with the following history:—Three days before admission he had severe hæmorrhage from the rectum unaccompanied by pain or other symptoms. The hæmorrhage recurred on many occasions, and the boy began to suffer from the effects of loss of blood. The bowels were open before the first hæmorrhage, but had not acted again before admission; there were no signs of intestinal obstruction. On admission the boy looked pale, but was in no discomfort. A loss of bright blood occurred soon after he entered the hospital. Rectal examination was negative except that the rectum was ballooned. On examining the abdomen there was no distension, but a tumour, one inch in long diameter, was felt in connection with the sigmoid flexure. This lump was freely movable across the axis of the intestine, and was tender on pressure. The boy was otherwise apparently healthy. The probable diagnosis of polypus was made and in view of the fact that the boy was evidently suffering from loss of blood, it was decided to open the abdomen and deal with the condition as was found necessary. On the abdomen being opened, the sigmoid was found to be bound down by a broad, firm adhesion fixing the meso-sigmoid to the pelvis; at one point the adhesion extended as far as the gut, where it caused an acute kink. Palpation of the sigmoid proved that there was no polypus. The lumen of the gut was easily restored by separating the adhesion. The abdomen was then closed. Mr. Carson said that the cause of the adhesion was obscure, the only abnormality present being a number of small shot-like glands in the meso-sigmoid. He considered that in this case the hæmorrhage was due to the kinking of the sigmoid causing acute hyperæmia of a portion of the lining mucous membrane of the gut. He thought it was very probable that intestinal obstruction would have soon supervened. Discussing the causes of rectal hæmorrhage in children, he pointed out that it is comparatively rare, and when present almost invariably due to polypus. In making a diagnosis in this case the most likely causes of trouble seemed to be either a polypus in the sigmoid flexure or an intussusception. The former appeared the more probable owing to the character of the hæmorrhage, which was arterial in appearance, whilst the absence of any signs of intestinal obstruction would render the presence of the latter very doubtful.

A few hours after operation the boy passed a small quantity of blood and from that time he had no further symptoms. On his leaving the hospital three weeks later the lump was no longer palpable, and the patient declared himself as feeling quite well.

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“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, MARCH 15, 1905.

THE REFORM OF THE IRISH MEDICAL ASSOCIATION.

IN our recent articles on Surgeon-General Evatt's report on the Irish Poor-law Medical Service, we indicated that we should in our next issue return to what is at the present moment the most important matter in Irish medical politics, namely, the reform of the Irish Medical Association. This body needs not alone the support and work of its active members, but also the healthy stimulus which friendly criticism can give. It is admitted on all sides that the reform of the Association is a pressing matter, and that what ought to be an influential and important body can no longer be allowed to remain in its present unsatisfactory condition. The Association brought over Surgeon-General Evatt at great expense to report on its present condition and to suggest reforms. By one of those unfortunate “accidents” that are too common in Irish affairs, the absurd and impracticable portions of his report have become public, and have attracted general notice and adverse criticism, while the portion from which the Association may not unfairly expect to receive benefit is as yet an official secret. It may not be out of place if, while the Council of the Association debates the treatment to be awarded to the remainder of Surgeon-General Evatt's report, we place before our readers the nucleus of a scheme of reform, which may serve to turn in a suitable direction the thoughts of those on whom the actual drafting of a reform scheme must devolve. Constructive criticism is always difficult, and in this case it is beset with special difficulties, while a purely destructive criticism is valueless. Two items of destructive criticism we may, however, bring forward. The Irish Medical Association should not be nominally governed by an unwieldy Council of some seventy members selected not

by branches, nor by county representatives, but by the whole body of the Association; nor should it be actually governed by a Committee or Council of eight members, of whom five are the medical officers of the same Union. What should be substituted for these bodies, the one suffering from the inertness of mass, the other from the over-activity of almost complete independence? We should like to see the Association reorganised in some such manner as this:—Every member should be attached to a county Branch, whose business should be to promote social intercourse between its members, to send representatives to a Provincial Council, and to report to the Provincial Council on all local matters affecting the welfare of the profession. The Provincial Council should consist of representatives sent forward by the Branches. Its duties should be to elect representatives for a General Council, to bring before the General Council all matters with which it was not itself empowered to deal, and to administer such portion of the funds of the Association as was allocated to it, and which should represent a certain percentage of the subscriptions of the provincial members. To this Provincial Council should also be given the power of fixing the salaries of, and general conditions under which, Poor-law and other medical appointments should be held, with the safeguard of the right of appeal to the General Council of any member who might feel himself aggrieved. The General Council should consist of the President of the Association and of representatives sent forward by the Provincial Councils. It should meet quarterly and when occasion required. It should control the funds of the Association, save such portion as should be allocated to the Provincial Councils, and with it should rest the final decision on, and responsibility for, all measures undertaken by the Association as a whole. The Central Council should consist of two representatives from each Province, and so, with the addition of the President of the Association, would consist of nine members. The Provincial Councils should consist of ten representatives from the Branches, and so, with the addition of a Provincial President, would consist of eleven members. The Branch representatives should be elected on an automatic system, based on the number of members of each Branch. The points in this scheme which appear to us to be most important are as follows:—First, the Provincial Councils are entrusted with the management of all provincial affairs up to a certain point, and with the control of a certain proportion of the funds collected in their own provinces. Secondly, the Central Council is elected by representative men from among their own number, and so the suitability of its members is twice tested, and only those men are selected who are likely to take an active interest in the affairs of the Association. Thirdly, the Central Council is of reasonable size, and is thoroughly representative of all parts of Ireland.

THE EXCLUSION OF SCOTCH AND IRISH DIPLOMATES FROM ENGLISH HOSPITAL APPOINTMENTS.

IN another part of the present issue (page 270) readers will find a report of the inaugural general meeting of the recently-formed Association of the Diplomates of Scotland. The subject chosen for discussion at the first meeting of that body was appropriately that of the exclusion of Scotch diplomates from most of the large London and many of the provincial hospital appointments. It is difficult to understand how so obviously unfair a regulation could have become part and parcel of the rules of any medical charity. The fact of its general adoption may probably be explained by the long-continued influence and combined pressure of the London colleges concerned and of their diplomates, and by the want of organisation among Scotch and Irish diplomates. The latter contributing factor, it is to be hoped, will be removed by the new Association of Scotch Diplomates. Their brothers in the wilderness, to wit, the Irish collegiates, many years ago formed a strong organisation which has done yeoman service in educating the public as to the manifold injustices inflicted by the exclusion of many able and honourable medical men from hospital staff appointments. Not content with mere protest, the Irish Medical Schools' and Graduates' Association has actually circularised governors and obtained a removal of the excluding regulation from hospitals at Bristol, Hastings, Brighton and elsewhere. Now that their labours in this direction are reinforced by the Scotch colleges and the Scotch diplomates, it is to be hoped that the professional world will be purged of a most obnoxious class privilege, savouring of mediæval rather than of enlightened modern ethics. Reduced to plain statement, the effect of the restriction of a number of the chief hospital appointments in London and to a less extent elsewhere, is enormously to enhance the value of the London Colleges of Surgeons and Physicians. As pointed out by one speaker at the meeting above referred to, it practically reserves to the London Fellows the key to large and lucrative consulting practice. The exclusion of Scotch and Irish Fellows at once narrows the field of competition by two-thirds. It is certain that the hospitals themselves must lose by thus artificially restricting the source of available recruits. There is no guarantee that the possession of the London fellowship secures the best and most original brains or the most capable and energetic men as honorary physicians and surgeons. Were that elementary fact brought home to the public the days of exclusiveness would forthwith be numbered. The public is injured not only by excluding good men from the hospitals, but also by the loss of capable men who are denied a reasonable chance of rising to the front ranks of their profession. One of the speakers at the recent discussion asked pertinently whether the Scotch and Irish Fellows were excluded because

their professional knowledge would not compare favourably with that of the English diplomates, or, on the other hand, because the London men shrunk from competition on equal terms? In the first case there was surely no need to fear competition, and in the latter they inflicted a serious injury upon the hospital patients and upon the public generally. That is a dilemma which should be presented in its naked simplicity to every hospital governor in the United Kingdom, for it must be remembered that in their hands lies the ultimate making or unmaking of the rules of individual institutions. As to the absolute and crude elementary justice of throwing open hospital appointments to the diplomates of all medical colleges admitted to the *Register*, the point is hardly open to reasonable argument. In all parts of the Kingdom many physicians and surgeons holding the London college qualifications have freely and openly cried shame on these hospital disabilities. More than that, the British Medical Association have at three of their annual meetings passed resolutions condemning the exclusion of provincial diplomates from London and other hospital appointments. The General Medical Council, with its usual academic aloofness, declines to interfere in any way. The Scotch and Irish colleges have not hitherto bestirred themselves sufficiently in the matter. It now remains for the Scotch and Irish diplomates to educate the public and the profession to the pitch necessary to find a remedy for what has grown into an intolerable abuse. The tendency of the London men to take what they can get is understandable enough. It remains, however, for the medical profession and the public to insist that whole bodies of Scotch and Irish graduates of ability and integrity shall be no longer grievously handicapped in their career by exclusion from many of the chief prizes of professional life.

Notes on Current Topics.

Dublin Corporation and Consumptive Sanatoria.

THE Dublin Corporation had some discussion the other day on a matter of great importance to the public health—namely, the provision of hospital accommodation for consumptive patients. It was started by the Chairman of the Public Health Committee pointing out, in presenting his report on the inspection of the Dublin hospitals receiving grants from the Corporation, that these hospitals were unwilling to receive consumptive patients, and that if consumptives were admitted to the wards by accident, they were dismissed at the earliest possible opportunity. We have no doubt that Alderman McCarthy is quite correct in his statement—though it was contradicted by one of his colleagues—and if so, the hospitals are acting quite rightly. Neither in their own interests, nor in that of the other patients in the wards, is it right

that consumptive patients should be treated in general hospitals. The suggestion was made that the Corporation should seriously consider the advisability of providing a sanatorium of their own for consumptive patients, as has been done at Manchester, Cork, Belfast, and other places. We believe that this is the only proper solution of the question, but it will have to be done on a large scale to be effective. The sanatorium will have to be, not merely a curative institution, but, for most cases, cure being impossible, an isolation hospital. As consumption is an extremely common disease among the poorer classes of Dublin, it will be necessary, if a sanatorium is to be built, to make provision for a very large number of patients. In the meantime, it has been suggested that certain of the hospitals, in receipt of municipal grants, should be asked to make provision in separate wards for a limited number of consumptive cases. There should be no difficulty in doing this, as many of the hospitals have empty wards available, but it is questionable whether it is a wise proceeding. The surroundings and structural arrangements are not such as are suitable for consumptive patients, and it would be difficult to make the necessary changes on a small scale. Moreover, no such arrangement can be more than a makeshift, and one, which if at all successful, only tends to postpone a proper settlement of the question.

Recruiting Returns.

THE Annual Report of the Director of Recruiting and Organisation for the Army and Militia has just been issued, and it shows the numbers presenting themselves for enlistment, and the numbers rejected for the last four years and nine months. These returns have been frequently referred to in our columns, and this year's issue does little to allay the alarm that was naturally excited by the figures published in previous years. Although the actual number of candidates rejected has fallen since 1902, the total rejection is still greater than in 1900, and amounts in actual figures to no less than 24,658 for the twelve months ending in September last. The percentage rejection, however, is steadily rising, the figures for the last five years being:—1900, 27·4; 1901, 29·04; 1902, 32·22; 1903, 33·83; 1904, 34·39. It is little less than appalling to think of what this means to the country at large, and what a state of general physique it connotes. Recruits who wish to enlist are men who presume themselves healthy, and able to stand the rigours of a soldier's life; and yet of these more than a third are found unfit to attain the very moderate standard demanded by the military medical officers. The significance, moreover, is increased by the fact that whereas larger numbers of soldiers are wanted, smaller numbers are coming up for enlistment, only 41,279 applying for the Regular Army last year, and 35,264 for the Militia. Though the report expresses the hope that the new conditions of pay will attract a higher class of men, even this

desideratum will not do away with the fact that a third of the youth of the poorer classes is below par in health and physique.

Police Search in a Hospital.

AN outrage of a peculiarly offensive nature, and, we are glad to say, of a rare kind, was recently committed by the Montreal police, and is exciting much interest in hospital circles in Canada. It appears that a man was being prosecuted on a charge of seduction, at the instance of the parents of a young woman. When the case came on, the latter was not to be found, and a warrant was issued for her arrest as a material witness. It was rumoured that she was an inmate of the Montreal Maternity Hospital and two police officers went there to search for her. Presenting a document which they stated to be a search warrant, they insisted, in spite of the protests of the medical officer and the lady superintendent, in visiting every apartment of the hospital. They forced their way into the lying-in wards, examined the patients closely, and peered under the beds. They even visited the private apartments of the nurses, in some of which the night nurses were sleeping. During all the time they behaved in a very offensive manner, keeping on their hats, and by their violent conduct causing great annoyance to the patients. The Hospital Board has very properly made a strong protest, and has called for the dismissal of the police officers concerned. It appears, moreover, that the document declared to be a search warrant was nothing of the sort, and the proceeding was entirely without legal authority. We trust the hospital authorities will succeed in inflicting condign punishment for such a wanton outrage.

Locomotor Ataxia and Ultra-Violet Rays.

IN so hopeless a condition as locomotor ataxy one grasps at every new method of treatment which is not founded on radically vicious lines as offering perhaps some hope of relief or cure. A paper by Liebermann in the *New York Medical Journal* for the 18th of last month suggests that this complaint may really be amenable to light treatment, and the cases he narrates certainly are encouraging. Of course, the most important factor is to obtain patients in the early stage of the disease, preferably in the pre-ataxic stage. The plan adopted by Liebermann was to apply the ultra-violet rays given off by a lamp excited by a static machine to areas of the spine which had previously been subjected to local cataphoric de-hæmatisation. The remedy he regards as a potent one, and he thinks it should never be applied to more than two areas at the same sitting, but that each division of the cord should be dealt with in rotation. After the treatment the patient was given a warm bath and light massage before being put to bed. Of thirty-six cases so treated, he claims that four were restored to health and enabled to resume their occupation, while twelve improved greatly, all pain being

abolished and co-ordination restored in the muscles of the limbs. Of the rest, in eighteen the disease appeared to be arrested, whilst two died during the treatment of extraneous causes, namely, pneumonia and erysipelas of the head. Liebermann is much encouraged by these results, and is pursuing his investigations. If they establish the value of his method, a great and important future should open up for this means of treating organic nervous disease.

Serum Treatment of Syphilis.

THE marked success of serum treatment in the case of a few diseases due to infection by known organisms naturally encourages us to search for similar specific treatment for other diseases. We are not content, either, to limit our investigation to diseases of known bacteriology, but attempts are made to discover antisera even for those whose organisms are yet undiscovered. Attention was recently drawn to the production of a serum for cancer in the States, although no pretence was put forward of having discovered the causal organism. Now there comes news from Italy of the successful treatment of syphilis by a specific serum. Risso and Cipollina treated a number of dogs by the injection of blood from patients in the secondary stage of syphilis, no antisyphilitic treatment having been received. When the dogs had been treated by three or four injections at intervals of five or six days, their blood was drawn and made use of. The patients treated were sixteen in number, and they received no other antisyphilitic treatment. The authors state that all the papular and macular lesions disappeared more quickly than is usual under mercuric treatment. Nine patients were apparently entirely cured, and four others much improved. In one case a gumma of the nose disappeared after twelve injections. The authors believe they have discovered a true specific serum, and they appeal confidently for further trial.

Brandy Again.

THE question of what is brandy is one that has more than a commercial or epicurean interest to medical men, and it was hoped that the *Lancet* Commission on the subject in 1902 had defined the ground covered by the term pretty clearly. A good many prosecutions in different towns have taken place lately, and these show in general that it is not difficult to get a conviction when brandies are adulterated with silent spirit. But as if to upset the happy dream a critic comes forward in the *Analyst* of last month to show that it is frequently impossible for analysts to say whether a brandy is really derived from grapes or not. Otto Herner, the writer of the paper in question, argues that "brandy" is a much more widely-reaching term than "cognac," for it is obvious that a wine-distillate obtained from other than the Cognac district has a right to be regarded as brandy, although it did not come from grapes grown in that district. Analysts seeking for distinctions between spirits have to

avail themselves of the "impurities" with which the pure alcohol is associated for grounds of difference, and the co-efficient of these, says Herner, vary in different wine-distillates obtained in different countries to so large an extent that no definite conclusions can be drawn from them. Furfural, which has been claimed as a characteristic "impurity" of brandy, has been shown by Windisch to be a product of the decomposition of pentoses, and is by no means always present in wine-distillates. Finally, with regard to ethers, Herner himself has met with wine distillates in which the ether co-efficient was much lower than 80, and as others have noted differences varying between 18 and 450, no definite conclusion can be drawn from this factor. Altogether the whole subject would seem to have been thrown back into the disorganised and unsatisfactory state from which everyone hoped it had finally emerged.

Tubercle and Occupation.

THE relation that holds between the various occupations and the incidence of tuberculous disease has not received at all the attention it deserves. The figures probably differ very much in different countries, owing to the conditions of labour varying, but nevertheless the ratio published by Dr. Huber, of New York, (a) with reference to the incidence on the different occupations in that city, are interesting to us in this country. One remarkable conclusion seems evident as an influencing factor in determining the percentage of those employed in a given occupation who suffer from tubercle—the predisposing causes are of more importance than the exciting. In other words, the soil is more important than the seed. The cause, above all others, which tends to produce a favourable soil for the implantation of tubercle in the lungs is the inhalation of irritating particles or vapours. Although the connection between stone-grinding and such occupations and tuberculous disease has long been known, yet it comes as a surprise to us that the tuberculous death-rate among marble and stone-cutters is six times that among bankers and brokers, to choose an indoor occupation, or among farmers and farm labourers, to choose one that is pursued out of doors. Among cigar-makers and other tobacco workers the rate is extremely high, and is probably due to the constant irritation of the air passages by tobacco, in addition to the fact that this occupation is often carried on in most insanitary surroundings. It is curious to find that some classes who lead an apparently healthy open-air life, such as sailors and fishermen, stand high in the list, being wedged in between barbers and hairdressers on the one hand, and painters and glaziers on the other. Indeed, one could not, from Huber's tables, draw any conclusion as to the effect of an open-air life on the incidence of tuberculosis. It is some reassurance to our profession that they stand quite low in the list, for though doubtless exposed to infection, medical

men probably safeguard themselves in a way unpractised by members of other professions.

Curiosities of Graves' Disease.

IN January of this year in two New York medical societies curious instances of Graves' disease were reported. At the New York Neurological Society, Dr. Arthur Booth showed a case of a girl, *æt.* 13, suffering from well-marked exophthalmic goitre. The child had enjoyed good health, except for various infantile complaints, till she was eleven, when, without any recognisable cause, exophthalmos was noticed. Six months later enlargement of the thyroid took place, and this was succeeded by tachycardia, tremor, sweating, insomnia, and general nervousness. At the date of presentation to the Society all the symptoms were well marked. The other cases mentioned above proved the subject of a paper by Dr. John Cotter in the Section of General Medicine of the New York Academy of Medicine. Although not remarkable in themselves, they were of great interest when taken in association with each other, as the whole series occurred in members of one family. The father of the family was in good health, but the mother was said to have died of "full-neck" and valvular disease of the heart. The children, four in number, all suffered from symptoms of Graves' disease in more or less marked degrees. These members were a girl, *æt.* 12, who had a full thyroid and slight tachycardia, but recovered under treatment; a woman, *æt.* 28, who had nervous symptoms and full thyroid; a younger sister, *æt.* 19, who had tremor, thyroid enlargement, tachycardia, and cardiac hypertrophy; and, finally, a brother, *æt.* 17, with greatly enlarged thyroid, dyspnoea, and rapid pulse. Although none of this group had actual exophthalmos, there was no doubt that their complaint was Graves' disease in a modified form, and its occurrence in four consecutive members of the family was not a little remarkable.

Vegetarians at Windermere.

AN entertaining account is given in *Chambers' Journal* of the pranks of a body of health-culturists, who met last summer at Bowness, Windermere, to have a happy, hygienic summer holiday. The meeting was planned on the "common basis of vegetarianism, physical and mental culture, and hygiene," and a bizarre crowd of both sexes assembled in response to the clarion-note of the organiser. At the cry of "Gym," the frisky alderman, the prancing matron, and the ecstatic daughter came bounding up each morning, and led by two skittish maidens in white bloomers and floating sashes, the motley crowd, divested of all superfluous clothing, began a wild sort of can-can. The performance began as a march, continued as a trot, broke into a run, went on as a hop, skip, and jump, turned into a general *mêlée* of exercises for every muscle of the body, and wound up by a dignified finale in which the

(a) *American Medicine*, January 21st, 1905.

members lay on their backs and worked their limbs vigorously in the air. Other sports followed till dinner-time, when nuts, lentils, apple-dumplings, and hydropathic pudding put fresh life into the performers, and then off they went in quest of fresh excitement and health. Salad, cake, and potted haricots beguiled the evening hour, till, weary with their culture and creed, the enthusiasts fell into a dreamless sleep. Thus the merry days went by till this happy holiday had renewed the jaded frames of the "culturists" sufficiently to enable them to return to their more prosaic surroundings. It will be interesting to observe if this sort of movement catches on; at any rate, it is not for medical men to condemn it. It will certainly make more for health and happiness, and be not one whit less ridiculous than yawning away a month with French novels, fashionable clothes and nigger entertainments by the sad sea waves at Brighton or Eastbourne.

Cats and Dogs.

A GREAT fuss was made by many of the excitable dailies a week or two ago consequent on the disappearance of several cats from Bedford and its vicinity. It appears that two men were arrested at that town on the charge of stealing cats, and it was stated in evidence that boxes containing cats had been consigned by a dealer to whom the prisoners sold the animals, from Bedford Station to an address in South London. The evening papers discovered that the address was that of "a house much frequented by medical gentlemen." Sensational headlines thereupon appeared on the placards: "Stolen Cats Consigned to a South London Mansion—For What?" "Amazing Vivisection Establishment in South London," "Fate of Lost Cats. Secret of a Mysterious Institution," "The Cat Hunters: Mystery of a Herne Hill Mansion Explained," and so on. What was the explanation of this wonderful mystery? The address was that of the Wellcome Physiological Research Laboratories, and where the mystery comes in it is hard to see. The institution is well known to the profession for the bacteriological researches there conducted. Diphtheria antitoxins and other sera are there produced. It is registered with the Home Office as a place for experiments on living animals, and three of the staff are licensed by the Home Office to perform such experiments. All of this is writ large in blue books, containing the reports of the Government inspector.

Caterpillar Rash.

ONE of the curiosities of skin eruptions is that resulting from the touch of certain caterpillars. Many cases of this sort have been recorded, but for the most part their pathology has been undiscovered. During the past few years, however, a large number of cases have occurred in New England, and Dr. Towle, of the Massachusetts Hospital, has had an opportunity of studying the condition.

He describes it (*a*) as an acute dermatitis accompanied by severe and often intolerable itching. The lesions were firm red wheals, which often lasted several hours, while the eruptions as a whole might go on for weeks. It not only appeared at the site of irritation, commonly the neck, but in many cases it spread over the back, chest, and arms. The pathology of the condition has been studied by Dr. Towle, and also by Messrs. Fernald and Kirkland of the State Board of Agriculture. It is caused by the caterpillar of the "brown-tail moth," which appears to have been introduced accidentally from Holland about ten years ago, and during that period has caused great damage to the vegetation of a limited district of Massachusetts. This animal is furnished with strong, though minute, barbed hairs, and it is the penetration of the skin by these hairs that causes the acute dermatitis. In all the lesions, the hairs can be demonstrated beneath the epidermis. It is believed that the irritation is entirely mechanical, as all attempts to separate a chemical poison have failed.

Railwaymen's Peril.

THE hardships and grievances of railway servants, such as overwork, underpay and incidental risks to life and limb, are not brought before the public with the same degree of prominence that is accorded to other dangerous occupations. At a recent meeting of the Amalgamated Society of Railway Servants, Dr. Macnamara, M.P., showed, from the Great Eastern Railway figures for October, 1903, that of 1,291 engine-drivers and firemen, 84 per cent. had worked at various times during the month more than twelve hours at a stretch; 320 worked more than fifteen hours; 56 more than sixteen; 12 more than seventeen; and 2 more than eighteen hours. Among signalmen a similar stress of work is recorded. Considering the great responsibility of each of these men, it is a matter of some surprise that such a state of things should be allowed to go on. It has more than once happened that a signalman has been found guilty of an "error of judgment" after some terrible accident has taken place, whereas if the truth were known, it would probably be found that this official was suffering from sheer fatigue and nervous exhaustion. Long hours of duty with inadequate intervals must sooner or later cause the strongest constitution to break down, and such a condition of things clearly constitutes a "standing menace to the safety of the public." There is also the additional danger to drivers and linemen from fog, and several of the latter class of servants meet with untimely death from being run down by passing trains. The public are looking forward to the increased facilities for travelling offered when the London Underground Railway is electrified, and to extension of electrical railways throughout the kingdom, but if cleanliness and speed are to be purchased at the expense of cutting down the wages of the

(a) *Boston Med. and Surg. Journ.*, January 19th, 1905.

railwaymen, and of rendering it difficult for them to obtain their meals under healthy surroundings, such an event had better be postponed.

Where is the St. Thomas's Hospital Pathologist?

THE London newspapers of the 11th inst. contain the report of an inquest held by Mr. Troutbeck upon the body of a patient who died recently at St. Thomas's Hospital, while undergoing an operation upon the throat. Although the unfortunate accident took place in one of the largest and best-equipped hospitals of London the Coroner appears to have handed over the *post-mortem* examination and report to Dr. Freyberger, who is the specially privileged pathological expert attached to the Lambeth Coroner's Court. The same individual enjoys a sort of semi-official recognition by the London County Council, and he is frequently described by public reporters as the "L.C.C. expert." As a matter of fact, he is nothing of the kind, as no such post exists, and it is hard to believe that the Council would fasten so flagrant an injustice and insult upon the medical profession as that entailed by an appointment of the kind. As a simple matter of fact, Dr. Freyberger has no special claim to be considered a scientific "expert," and in a great number of instances he is less qualified to give trustworthy evidence as to the cause of death than the general practitioner who has been in attendance upon deceased. In the case under notice he informed the Court that death was caused through air entering the heart, presumably through the accidental severance of a vein. Why did not the house surgeon at St. Thomas's conduct the *post-mortem* examination? Where was the hospital pathologist, or did Mr. Troutbeck deliberately prefer the "expert" testimony of Dr. Freyberger?

Artistic Breathing.

It is a recognised principle among public speakers and singers that proper control over the breathing apparatus must be obtained before the voice can be used to its fullest advantage. Yet it would appear, if multiplicity of methods and schools be any indication, that some doubts exist as to the right manner of producing the voice. It is somewhat unfortunate that the word "produce" is used in this connection, for surely the emission of a tone by the larynx is a purely natural act, capable of modification by voluntary effort and training. The singing bird does not trouble himself about voice-production. His melodies delight the human listener, who only wishes that he could use his vocal organs with equal effect without having to undergo a prolonged period of training. The greatest singers, whose depth and purity of tone have aroused the admiration of the world, have always understood the management of the breath. It is not necessary, of course that a singer should know every anatomical detail concerning the respiratory organs, but it is essential that he or she should know how to

manage the wind-chest and "bellows," as it were, attached to the organ of voice. The great secret possessed by the old Italian school, whose fame in producing singers is universally acknowledged, consisted simply in copying Nature's method of breathing, namely, that of full and complete inflation of the thoracic cavity, combined with the conservation or economy of the air thus taken in. All constriction of the upper air-passages caused by the vocalisation of certain consonantal and vowel sounds is also eliminated. In a small *brochure* by the Rev. Charles Gib, of St. Philip's, Buckingham Palace Road, entitled "Artistic Breathing," the principles of this school are simply expounded, and we fully agree with the author's statement that if habitual deep breathing were more generally practised, various physical troubles might be prevented.

PERSONAL.

HIS MAJESTY THE KING has very graciously acceded to a suggestion that the skeleton of Ambush II., the famous steeplechaser from the Royal stables which died some weeks ago, should find a place in the Museum of Veterinary Anatomy at the University of Liverpool. His Majesty was approached on the subject by Mr. J. T. Share-Jones.

THE DUKE OF CONNAUGHT has consented to take the chair at a festival banquet, to be given at the Savoy Hotel on May 17th, for the purpose of raising £10,000 for the Great Northern Central Hospital.

At an ordinary meeting of the Council of the Royal College of Surgeons of England, Mr. John Tweedy (president) in the chair, Mr. W. H. A. Jacobson and Mr. Bilton Pollard were admitted members of the Court of Examiners.

At the same meeting, Mr. Henry T. Butlin, vice-president, was appointed Bradshaw Lecturer for the ensuing year.

DUKE CARL THEODORE OF BAVARIA, the famous royal oculist, has lately celebrated his jubilee of twenty-five years as a doctor. His Royal Highness, who is a brother of the late Empress of Austria, took up the study of medicine when he left the army, and studied in Munich, Zürich, and Vienna.

DR. WILLIAM W. IRELAND, Musselburgh, was presented by his professional brethren last week with an illuminated address and a sum of money in celebration of the fiftieth anniversary of his medical graduation, and in recognition of his services to medicine.

MISS TADA URATA, of Kumamoto, Japan, has just obtained the degree of Doctor of Medicine at the Marburg University, this being the first time that Marburg has granted a doctor's degree to a lady.

ON the 9th instant, at Christ Church, Clifton, Dr. Julian Dreschfeld, the well-known physician, of Manchester, was married to Miss Ethel Lilley, daughter of the late James Harvey Lilley, M.D., of Leamington.

At the 28th annual meeting of the Irish Medical Schools' and Graduates' Association, to be held on Saturday next (the day after St. Patrick's Day), Surgeon-General Sibthorpe, C.B., will resign the Presidential Chair to Sir William Whitla, who will preside at the festival dinner the same evening at the Hotel Cecil, London.

It is announced that Dr. Doyen, the Paris surgeon, will visit London either at the end of March or the beginning of April, and will probably deliver a lecture on the subject of cancer and its treatment.

DR. W. B. NORRIS has been appointed Chairman of the Board of Public Health and Medical Inspector of the State of Victoria, Australia.

DR. F. GRÖNE, formerly of St. Bartholomew's Hospital, has been appointed Assistant Medical Officer of Health in Hong Kong, in place of Dr. B. L. T. Barnett.

THE Sir Gilbert Blane's medals of the London College of Surgeons have been awarded to Surgeon Sidney Thomas Reid, his Majesty's ship *Vestal*, 1901-2, and Surgeon Robert William Glennan Stewart, M.B., his Majesty's ships *Latona* and *Thames*, 1903.

MR. JORDAN LLOYD, professor of operative surgery, has been elected to represent the Faculty of Medicine upon the Council of the Birmingham University, *vice* Professor H. G. Barling, who as Dean of the Faculty is *ex officio* a member of the Council.

THE Huxley lecture this year will be delivered at Birmingham University on Thursday, March 23rd, by Professor E. B. Poulton, M.A., F.R.S., of the University of Oxford.

PROFESSOR JOHN E. SHORROCK MOORE, F.L.S., has been appointed director of cancer research at the Liverpool Royal Infirmary in succession to Professor A. S. F. Grünbaum. As professor of natural history at the Royal College of Science, London, Professor Moore is well known as an investigator in cancer. He has also distinguished himself by his explorations in Central Africa.

LIEUT.-COLONEL G. S. A. RANKING, of the Indian Medical Service, has been appointed Professor of Arabic, Persian, and Hindustani in Trinity College, Dublin. The new Professor gained the Herbert Prize at Netley in 1875, and was formerly Chemical Examiner to the Indian Government and Professor of Chemistry in the Medical College, Calcutta.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

SCOTLAND.

REPORT OF THE CARNEGIE TRUST FOR THE YEAR 1904.—This report, which has just appeared, is too long to quote *in extenso* here, but it is satisfactory to learn from it that the funds at the disposal of the trustees for the three main objects of the trust, *viz.*, endowment of teaching, endowment of research, and payment of class fees, have been more than adequate to meet the demands made on them. The sum available was £40,000 per annum, of which £38,114 has been paid in 1904, or a total expenditure of £58,479 during the first two years of the quinquennial period. The fact that not all the money has been applied for is due to the inevitable delay in carrying out extensive building operations. During the next quinquennial period, when the need for buildings is satisfied, the trustees hope to be able to devote a larger proportion of the annual income of the trust to direct endowment of lectureships and chairs, the sum claimed for this purpose during the past year having been £11,568. In the present quinquennial scheme of grants the following extra-mural bodies have been included as participants: The School of the Royal Colleges, Edinburgh, Edinburgh Medical College for Women, Anderson's College Medical School, Glasgow Technical College, Heriot Watt College, and the West of Scotland and Edinburgh Agricultural Colleges. Under the research scheme appointments were made to ten fellowships and to twenty-four scholarships. Allusion is also made in the report to the successful working of the College of Physicians' Laboratory recently purchased by the trustees.

JUBILEE OF DR. W. W. IRELAND, OF EDINBURGH.—

The fiftieth anniversary of his entrance of the portals of the medical profession was made the occasion of a presentation to Dr. Ireland of an illuminated address and a purse of sovereigns from a number of his professional brethren. Dr. Ireland is well known as a writer on psychological medicine, and his historical studies on that subject in his works, "The Blot on the Brain" and "Through the Ivory Gate," as well as clinical writings, "On the Mental Affections of Children," have given him world-wide celebrity. The presentation took place at the Royal College of Physicians, Edinburgh, and among those present were Dr. Playfair, President of the College, Dr. Clouston (who made the presentation), Drs. Yellowlees, Urquhart, G. M. Robertson, Joseph Bell, Underhill, James, Byrom Bramwell, Bruce, John Thomson, and many others, some of whom had travelled long distances to be present. Dr. Clouston, before reading the address, referred in appropriate terms to Dr. Ireland's industry, and to the intellectual power with which he had extended and placed on a sound scientific basis the subject of developmental defects of the human brain. Until Dr. Ireland began to study the subject it was one which had attracted little attention in this country, and by his work on it he had built up a deservedly world-wide reputation. In his reply Dr. Ireland alluded to the reasons which made him take up medico-psychology, recounting his experiences in the Indian Mutiny, where he lost an eye at the Siege of Delhi. When he was able to resume work, ten years later, psychological medicine presented an opening and he took it up; when he did so he found that those who had been fellow graduates with him had attained to positions of influence while he was comparatively left behind. He had tried to do his best at psychology, and felt deeply grateful for this testimony from his professional brethren of their appreciation of his work. The address was a very beautiful piece of illumination from the hands of Mr. Home, Edinburgh.

RELATIVE EXPENDITURE AT THE LONDON HOSPITAL AND THE EDINBURGH ROYAL INFIRMARY.—At the meeting of the managers of the infirmary on the 6th inst. some interesting figures were submitted. It seems that a deputation from the London Hospital visited Edinburgh in January to discover the secret of the economy practised here. Thereafter paragraphs appeared in certain London papers to the effect that the less expenditure in Scotch hospitals was due to the nationality of the patients, who ate porridge, preferred their meat boiled, and in consequence had plenty of soup; moreover, meat cost 3½d. a pound as against 4½d. or 5d.; window cleaning cost £20 a year as against £300 in London; no medicines were given, and no pensions paid. As this did not seem to the superintendent of the infirmary to be a fair account of the differences between the cost of maintenance in the London Hospital and the Edinburgh Infirmary, he made a comparison between the prices paid for meat, milk, tea, coffee, sugar, and butter in the two cities, with the following results:—Meat in 1904 cost a fraction over 6½d. per pound for home-fed beef and mutton as compared with 4½d. or 5d. for foreign meat in the London Hospital; to have purchased our meat at 5d. a pound would have meant a saving in 1904 of £1,163. Milk cost 10½d. a gallon as against 8½d. in London; to have bought at this price would have saved us £485. We give our patients tea, coffee, sugar, and butter; the London Hospital does not. The above six articles represent £11,152, or 69 per cent. of our food expenditure, while poultry, fish, and eggs form an additional 14 per cent. On four days a week the patients get roast beef; on the other three the meat is boiled. The diet scale has been approved by a committee of medical men, and economy has been practised without affecting efficiency. In 1903 the cost of provisions per bed in the London Hospital was £31 5s.; in the Infirmary, £20 11s. 8d. In 1904 the Infirmary paid £273 in pensions and £226 in window cleaning. In the face of these figures the hypothetical (kilted?) Scotsman who lives on broth and boiled beef

seems hardly to explain adequately the economical lines on which Scotch hospitals are managed. Part of the difference probably is due to the fact that no medicine is supplied to out-patients in Edinburgh Infirmary, part probably to the absence of any grants in aid of the medical school, and possibly (as a counterpart of the broth-loving Scot aforesaid) the Englishman, though his beef costs less, may eat more of it than his northern cousin.

Correspondence.

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

BOVINE TUBERCULOSIS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.
SIR,—In your editorial of February 15th, "Kitasato on Bovine Tuberculosis," you mention the fact of the absence of cow's milk from the dietary of the Japanese and Kitasato's negative conclusions as furnishing a strong support to Koch's views "as at variance with von Behring's doctrine that the starting-point of most tuberculous disease is an intestinal infection, suffered during childhood, from the ingestion of milk." I beg to call your attention to some Japanese facts not related in your remarks: that the women of Japan never wean their babies, even three of different ages will be nursed by the same mother. There is no artificial food for Japanese babies, saving river fish or rice-meal cakes. General wet nursing is the rule everywhere. Any woman will nurse a child whether it is hers or some other woman's. This promiscuous interchange of human milk is always going on, and you may readily see the danger from it of transmitting germs from a consumptive woman (not cow) through the milk. Surely if there is danger from cow's milk of transmitting tubercle germs, why not from a human being's milk? Moreover, the incubation period of consumption (in my opinion, at least) is very, very long.

I have just returned to New York with my own son, aged 15 years, cured of tuberculosis after six months' exposure in a tent on the Pocono Mountains of Pennsylvania, elevation 2,000 feet, temperature sometimes 20 degs. below zero. I took him there weighing 99 lbs., and bring him back entirely cured of cough, spitting, fever, &c., and weighing 141 lbs. He was practically cured after only four months. Pray, if his disease was not a lymphatic disease, how did forced proteid feeding cure him? This boy was infected with consumption eight years before this outbreak, and he was infected through his mesenteric glands, I am sure. He was not a bottle-fed baby, nor did he get his infection from his Scotch mother, of the Campbell clan, who was a splendid feeder. When he was seven years, his bones began to break easily, and he commenced to grow far faster than he should. To-day he is fifteen years old, and wears a twenty-years'-old youth's suit of clothing. He takes a nine and a half shoe. No other symptom of rickets was ever shown, excepting the readiness of fracture in bones. Lime salts were always given to him, yet after puberty he develops consumption. Why? Was it not because of some error in food, a chyliiferous error, or possible infection?

I believe with von Behring that there is more infection of tuberculosis through the intestines than by the lung route. In fact, I believe that the infection of the lungs is a secondary infection. Otherwise, why should the apex be the most usual seat of the disease, and not the base, where surely more of the infected air, if that was always the cause, must penetrate?

I have had this son now with me in New York for three months, and there is absolutely no return of any symptom pointing to consumption. He is cured simply by a change in diet. I do not think much of climatic factors other than by indirection, increase of nutrition.

I am, Sir, yours truly,

ALBERT S. ASHMEAD, M.D.

(Late Foreign Medical Director, Tokio Hospital,
New York, 456 West 24th Street. Japan.)

THE LINCOLN TYPHOID EPIDEMIC.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.
SIR,—In the excellent letter on the above subject which Dr. Walsh contributes to your issue of 10-day (March 8th), he remarks: "The question the country will want answered is, what is Lincoln doing to cope with the present terrible disaster?" It would be very satisfactory if one could agree with Dr. Walsh as to the attitude of the country; but no one who has much knowledge of the facts will expect any part of the country not directly affected by the trouble to take any active interest whatever in the situation. It would be more satisfactory if the country would seriously ask what Lincoln did to prevent the disaster, and to insist upon punishment being inflicted upon the men upon whom responsibility can be fixed. Unfortunately, no punishment beyond, perhaps, the sufficient one which the epidemic brings with it can be imposed upon the community whose indifference has allowed local government to remain in hands so little fitted for it. And then it must always be remembered that the epidemic, although it may touch the pockets of the guilty, will smite more sorely with suffering and death many innocent children and parents. The fundamental fact to be faced, not only in Lincoln but throughout the whole kingdom, is that the educated and cultivated classes, the men of light and leading, or at least of sufficient intelligence to appreciate the importance of modern sanitary science, decline as a mass to serve on local governing bodies, or to take any sufficiently active part in electing members of those bodies. The councils throughout the country, urban and rural, are very largely composed of, and in many cases dominated by, mean, ignorant, and vulgar men, who, if they have no sordid personal ends to serve, are often preoccupied by the desire to keep down the rates at any cost. If they attend to the letter they disregard the spirit of all the Acts of Parliament they are morally bound to administer. It would be easy to fill some columns of your space with illustrations of this state of things. I will mention only one. A medical officer of health is appointed by most local authorities; but as often as not he is paid only to give an insufficient part of his time to his duties, and cannot, if he would, conform to the law or carry out the regulations of the Local Government Board. He knows that he has no public opinion to appeal to, and that if he should venture to go in the least beyond the desires of his employers he will be deprived of his office, or have his miserable stipend docked. If the sanitary legislation which has been passed within recent years were properly administered, not only would epidemics of typhoid be unknown, but compared to the present state of things we should have almost a sanitary Millennium prevailing throughout the length and breadth of the land.

I am, Sir, yours truly,

M. O. H.

March 9th, 1905.

Obituary.

JOSIAH ALLEN, M.R.C.S., L.S.A., OF RIPLEY.

The death took place last week of Dr. Josiah Allen, of Ripley. Deceased, who had retired from the active practice of his profession for several years, was prominent in local affairs. He was educated at Queen's College, Birmingham, and took the London M.R.C.S. in 1857.

RALPH HODGSON, M.R.C.S.ENG., L.R.C.P.LOND.,
L.D.S.R.C.S.IREL.

MR. RALPH HODGSON, of Liverpool Street, Sydney, New South Wales, died suddenly in January last. He was a son of Captain Hodgson, late of the Grenadier Guards, assistant commissioner of the City of London police. He studied medicine at St. Bartholomew's, and took the M.R.C.S.Eng. and L.R.C.P.Lond. in 1885, and the dental diploma of the Royal College of Surgeons in Ireland in 1881. In 1887 he went to Sydney, where he occupied a prominent position and

did much good work before his death at the early age of 50 years.

Laboratory Notes.

We have received several new preparations from the Palisade Manufacturing Co., New York, and Andrus and Andrus, 46 Holborn Viaduct, London.

HEMABOLOIDS (NUCLEOPEPTONES).

Certain researches having shown that inorganic compounds of iron are only absorbed in the system to a very slight extent, if at all, the originators of this product conceived the idea of obtaining nucleoproteids rich in iron from certain vegetable food stuffs, and fortifying these with a synthetic organic compound of iron. The preparation also contains bone marrow extract and beef peptones. A palatable practically digested food rich in iron and phosphorus is thus obtained which gave us the following analysis, the results being stated in grammes per 100 c.c.:—Total solids, 9.62; ash, 0.90; iron, 0.427.

HEMABOLOIDS, ARSENIATED (WITH STRYCHNIA).

This preparation is made with the idea of enabling the physician to prescribe at one and the same time a hæmatinic, nutrient and tonic alterative. The arsenic is stated to be in the form of a true organic nucleate, and a tablespoonful of the preparation represents the equivalent of 1-40th grain arsenious acid and 1-80th grain strychnia. The preparation shows the following results on analysis, the figures being given in grammes per 100 c.c.:—Total solids, 13.71; ash, 1.06; iron, 0.41.

FORMOLYPTOL.

FORMOLYPTOL is an antiseptic and germicidal fluid containing, according to the formula on the bottle, 5 per cent. of aceto-boro-glyceride and 0.2 per cent. of formaldehyde in combination with the active antiseptic constituents of pinus pumilio, eucalyptus, myrrh, storax and benzoin. The preparation has a fragrant pleasing odour and dissolves in water to form a clear solution. It has been shown by eminent American bacteriologists that formolyptol compares favourably with a 1-100 solution of mercuric chloride, even killing anthrax spores. An examination of this product showed the presence of a boron compound and of formaldehyde, and we should think that this preparation from its evident germicidal action and its freedom from poisonous principles should prove very acceptable.

MIDWIVES ACT. (a)

It is of great importance at the present moment to realise the actual meaning of that part of the Midwives Act which comes into force after March 31st, 1905.

After that day no woman will be allowed to call herself a midwife, or to use any other name to make people believe she is specially qualified to practise as a midwife, unless her name is on the Midwives Roll.

This Roll, or Register, is compiled and kept by the Central Midwives Board, and a copy of it can be seen at the office of the County Council, borough council, urban or district council—whichever is the local supervising authority for the district. It is important that everyone practising as a midwife should inquire and find out, without delay, to which of these councils belongs the supervision of midwives in her district.

By a special clause in the Act, any woman who had been for at least one year in *bonâ fide* practice as a midwife before the date on which the Act was passed (that is to say, before July, 1902) may, before March 31st, 1905, claim to have her name put on the Roll, and thus become a certified midwife, without any examination whatever, provided she can give satisfactory references as to her having been in practice for the required length of time, and as to her character. The fee for registration is 10s.

Any midwife holding the certificate of the London

Obstetrical Society, or of a training hospital on the approved list, can also be registered without further examination, up to March 31st.

The advantage of being able to continue work as a certified and recognised midwife is so great that it is hoped that all the present midwives whose experience has rendered them fairly competent and whose services are in much demand will be willing to pay this fee and enrol themselves without delay.

In the case of village women in small practice, or other midwives who cannot afford the sum of 10s., assistance may be given if satisfactory references are produced as to the real need of the applicants by the Association for Promoting the Training and Supply of Midwives, Dacre House, New Tothill Street, Westminster, London, S.W. Particulars may be had from the Secretary, Miss Gill.

In other cases, application for enrolment should be made at once to the Secretary, Central Midwives Board, 6 Suffolk Street, Pall Mall, London, S.W.

It may be noted that there is no law, and never will be, to prevent any woman whatever, trained or untrained, from going to help another in emergency, in her hour of need.

Literature.

FIRST REPORT OF THE WELLCOME LABORATORIES. (a)

THE founding of the Gordon Memorial College at Khartoum is an event of historical importance, and one which is calculated to produce far-reaching results in the future. Meantime we have before us the first report of the Research Laboratories by their indefatigable director, Dr. Balfour. After describing the state of the building he goes on to give an account of the various mosquitoes found in the Sudan, and the measures adopted for their extermination. Then follows a beautifully illustrated description of noxious insects other than mosquitoes, among which are a number of beetles, bugs and flies. The second part of the report is taken up with a detailed account of the general routine work done in the laboratories by the staff under the direction of Dr. Balfour. Among the diseases referred to, we find malaria, hæmoglobinuria, beri-beri, and mycetoma. Pulmonary phthisis is mentioned as being very common among the native Sudanese. It is most frequently met with amongst women and children, the cause no doubt being the ill-ventilated mud dwellings of the people. With regard to smallpox, which at times is epidemic, it is pleasing to note that the natives recognise and appreciate the benefits conferred by vaccination. In the Sudan syphilis is described as being "a loathsome scourge." The mosquitoes of Egypt are extremely ably treated of by Mr. Theobald, the woodcuts being of peculiar interest and beauty.

From what we have said, it will be readily gathered that this report contains much of permanent value. The illustrations alone would make it worthy a place in any medical library. We trust this will prove to be only the first of a series of reports equally interesting. We congratulate Dr. Balfour on the enthusiastic manner in which he has faced the many difficulties of his new office. No doubt his labours will result in the amelioration of disease, and the well-being of the native races in Egypt. Our readers will find the perusal of this report a most fascinating study.

TRANSACTIONS OF THE ROYAL ACADEMY OF MEDICINE IN IRELAND. (b)

THE Transactions of the Academy of Medicine for the Session 1903-1904, is a bulkier volume than its

(a) "First Report of the Wellcome Research Laboratories at the Gordon Memorial College, Khartoum" By the Director, Andrew Balfour, M.D., B.Sc., M.R.C.O.P. Edin., D.P.H. Camb., Sanitary Adviser to the Indian Civil Medical Department, &c., &c. Khartoum: Department of Education, Sudan Government. 1904.

(b) "Transactions of the Royal Academy of Medicine in Ireland," Vol. xxii. Edited by John B. Story, General Secretary. Dublin: John Falconer. Pp. xxxix.—433. 1904.

(a) Circular published at the request of the Association for Promoting the Training and Supply of Midwives.

immediate predecessor, and presents evidences, we are glad to note, of more careful editing. In spite of the greater labour necessary for its production, it reaches us some months earlier than our experience in recent years led us to expect. As most of the papers have already appeared in print, many of them in our own columns, it is not necessary to discuss them at length. Valuable papers on typhoid fever have been contributed by Sir John Moore, and Drs. Travers Smith, Drury, and Parsons. Dr. Smith and Dr. Parsons each relate cases which clinically presented many symptoms of perforation, but recovery took place. Though there is no case on record where the occurrence of spontaneous cure of intestinal perforation has been established by subsequent autopsy, yet there is no sufficient proof that such cure may not occur.

The most notable surgical contributions to the volume are a paper by Sir Thornley Stoker on Suprapubic Prostatectomy, and a note from Mr. T. E. Gordon on his further experience in the surgery of the Gasserian ganglion. The principal part of the section devoted to obstetrics and diseases of women is made up of the obstetric and gynaecological Reports of the Rotunda Hospital for 1903, presented by the late Master Dr. Purefoy. The maternal mortality in the intern and extern labour departments shows some increase over last year—14 deaths out of 3,739 deliveries, as against 10 out of 3,866. Full notes are given of the fatal, as well as of many other interesting cases.

Dr. Earl contributes an exhaustive paper on the cytology of serous fluids. We are glad to see many evidences of original work among some of the younger Dublin men. The researches made by Mr. Stoney on the pelvic fascia, Dr. Moorhead on the causation of leukaemia, Mr. Johnston on the effects of pituitary feeding, and Professor Dixon on nerve-markings on the cranial vault, are signs of a lively inquiring spirit.

The volume is copiously illustrated, though the illustrations vary much in value. For special praise one may select the drawings of dissections of the pelvis given with Mr. Stoney's paper, just referred to, and Dr. Wigham's micro-photographs of pathological specimens in the Rotunda Report. The volume contains much of interest, and is a representative contribution to medical science from the Dublin school.

UNIVERSITY OF ABERDEEN ANATOMICAL AND PATHOLOGICAL SOCIETY. (a)

THESE proceedings constitute a volume of over 150 pages, of which the Society may be proud, as an evidence of its vitality, and of the interest which it apparently succeeds in maintaining among its members. A remarkable point about the volume is the number of contributions made to it by students, many of them being of considerable scientific value. Among such contributions are included records of the anatomical variations which were found from time to time in the dissecting room. Apart from the intrinsic value of such observations, their value from a teaching standpoint must be very great, for there is no doubt that a methodical collection of such a kind adds greatly to the interest of routine anatomical work, and leads the student to approach the subject, not as a learner merely, but also as an inquirer. Of the purely anatomical papers in the volume, that by Dr. Berry on "The Anatomical Variations presented by Two Cases of Twin Monsters" is of more than usual interest because of the original and ingenious developmental explanation which he offers to account for the abnormalities found. To properly understand his theory, the original paper must be read, but it may be stated that he has shown clearly, by the aid of diagrams, that the condition of a single duodenum and of a fused liver can only be understood by supposing the twins to have been developed from a single ovum without bilateral segmentation, and that the same theory explains the existence of a single amniotic cavity.

(a) "Proceedings of the Anatomical and Anthropological Society, 1902-04, University of Aberdeen." Published by the Aberdeen University Press, Limited.

The anthropological papers are six in number, and should prove of interest to anatomists, principally from the account of crania from Uganda which they contain. Of more interest to the general medical reader is the account by Dr. Low of the contents of the Aberdeenshire Cists. Ten of these cists are described, and their contents enumerated. The bones found within them show evidence of having belonged to a race of low stature, probably descendants of the Alpine race that inhabited Central Europe about the end of the Stone Age. This paper is illustrated by a series of excellent plates, giving pictures of some of the skulls described, and also of some of the urns which were found within the cists.

BERRY ON PRACTICAL OPHTHALMOLOGY. (a)

MR. BERRY is to be congratulated upon the production of this useful little volume. Although the number of works of the kind must be already far in excess of the demand, yet we shall be surprised if this manual does not make a place for itself, and successfully compete for patronage. It is well written, up-to-date, and practical. The chapters on errors of Refraction and Accommodation are for the most part excellent: nevertheless, the curious statement is made (page 457). "In order to get rid of the disturbing element of accommodation, many ophthalmic surgeons are in the habit of using a mydriatic. This is an altogether unnecessary inconvenience to which to put the individual examined. It not only unduly prolongs the examination, but often (owing to rays which pass through the more irregular portions of the corneal periphery being included in those which are transmitted through the widely dilated pupil), may lead to a wrong estimation of the refraction. Personally, I have never found it necessary to use a mydriatic for this purpose." Again, on page 458, he says, "a determination of the whole hypermetropia subjectively is only possible when the accommodation is paralysed." We doubt the soundness of the author's teaching as to the prohibition of mydriatics in the estimation of errors of refraction. In the case of children the question of inconvenience to which the paralysis of the accommodation gives rise need not be considered, while among young adults, although the disturbance of vision thus caused may be inconvenient, nevertheless the complete physiological rest which the mydriatic secures for the eyes, though brief, is oftentimes most beneficial. On page 158 is figured a condition of the cornea, which the author describes as "strumous pannus," he further explains that it is due to "long-continued strumous infiltration of the cornea." What precisely does he mean by "strumous" infiltration? The term is new to us in connection with trachoma, moreover, we were under the impression that the word "strumous" has ceased to be used in connection with anything. But criticism in minor details apart the undoubted merits of this manual ought to gain for it a wide popularity, and we can cordially recommend it.

RENTOUL ON TRACHOMA. (b)

ALTHOUGH there is "nothing new" in this *brochure*, yet it is calculated to prove very useful to practitioners and others, in that it provides a plain and concise statement of all the practical facts bearing upon the serious disease with which it deals. Trachoma, in being a preventable disease, should be prevented; of its contagious nature there cannot be a doubt, neither is there any doubt as to the conditions which underly and favour its incidence. It is a serious disease not only in its immediate, but in its remote effects, and in view of this foreign governments are now becoming alive to the necessity of debarring immigrants suffering from trachoma, from landing on their shores. Dr. Rentoul

(a) "Manual of Practical Ophthalmology." By Georg A. Berry, M.B., F.R.C.S., Ed. With 228 illustrations, mostly from original drawings. Edinburgh and London: Young J. Pentland, 1904.

(b) "Trachoma (Granular Conjunctivitis)." By Robert Reid Rentoul, M.D. Liverpool: Cornish and Sons, 1904. Price 2s. net.

sees some thousands of emigrants in the course of the year, and it is in consequence of the experience thus gained of trachoma, and in the fact that students are not fully educated in this important subject, that has induced him to publish this *brochure*.

Medical News.

Important Conference on the Teaching of Hygiene and Temperance.

THE Medical Conference which has been arranged to take place at the Examination Hall, Savoy, London, on Friday, March 24th, has for its main purpose the consideration of the value and the desirability of the teaching of hygiene and temperance in the schools of the country. The medical profession has been taking the keenest interest in the subject, as is evidenced by the fact that no less than 14,718 of its members last year signed the petition in favour of such teaching being made compulsory. It is desirable that all advance on this line should be on thoroughly sound principles, and it is therefore most opportune that such a Conference has been arranged in order that the profession in London may further consider the matter. Sir William Broadbent, Bart., will occupy the chair, and Sir Victor Horsley will state the present position of the scheme in reference to the teaching of hygiene and temperance in schools. He will be followed by Dr. Robert Jones, who will draw attention to the Report of the Inter-Departmental Committee on Physical Deterioration in so far as it deals with the subject. Sir Thomas Barlow will indicate the present position of the profession in relation to alcohol, and Mr. McAdam Eccles will introduce the question of the pharmacological and toxic properties of alcohol and how they might be more fully taught in the medical schools with advantage to the nation. The conference, at which discussion is invited, will be held from 5 p.m. to 6.30 p.m., and we understand that Dr. Wm. Collier, Dr. F. W. Mott, Mr. Pearce Gould, and others may take part in it.

Royal College of Surgeons of England.

At the meeting of the Council, held on Thursday last, March 9th, Mr. John Tweedy, President, in the Chair, Mr. W. H. A. Jacobson, F.R.C.S., and Mr. Bilton Pollard, F.R.C.S., made declarations in the terms of the Oath prescribed by the Charter of 1800, and were admitted members of the Court of Examiners. Mr. Cecil William Rowntree (University College and Middlesex), M.B.Lond., having passed the required examinations and conformed to the bye-laws, was admitted a Fellow of the College. Mr. William Herbert Towny was admitted a Fellow of the College. Diplomas for the Licence in Dental Surgery were issued to Messrs. John Joseph Armitage (Tottenham), George Edward McMahon (Birkenhead), Christopher John Storey (York), and George Holmes Smith (Watford). A report was received from the Board of examiners in Dental Surgery recommending, for adoption by the Council, synopses indicating the range of Examination in the subjects of anatomy, physiology, surgery, and surgical pathology for candidates for the licence in Dental Surgery. This report was adopted. A vote of thanks was given to the President for his Hunterian Oration and he was requested to publish the same. Mr. Henry T. Butlin, vice-president, was appointed Bradshaw Lecturer for the ensuing year. The Chairman of the Library Committee reported that the President had presented to the College eight volumes of fifteenth century books, forming a valuable and interesting addition to the collection of books of that period in the library. A vote of thanks was thereupon given to the President for his gift. The President reported that Sir Gilbert Blane's medals had been awarded to Surgeon Sidney Thomas Reid, H.M.S. "Vestal," 1901-2, and Surgeon Robert William Glennan Stewart, M.B., H.M.Ships "Latona" and "Thames," 1903. A letter was read from Mr. J. Ward Cousins, F.R.C.S., reporting the proceedings of the Central Midwives' Board during the past year, and a

vote of thanks was accorded to him for his services as the representative of the College on the Board. It was determined to hold a Fellows' subscription dinner at the College on the day of the Council Election in July next.

Royal College of Surgeons in Ireland.

WE have received the regulations for the coming summer session, commencing with the preliminary examination, which will be held on March 21st. The School of Surgery, Summer Term, will open on April 1st for the three months' course, when the following practical courses and lectures will be given—Operative Surgery, Practical Chemistry, Practical Histology, Materia Medica, Biology, Public Health, and Forensic Medicine, and a Course of Dissections.

The State-Feeding of School Children.

LADY WARWICK last week presided over a meeting convened by the Social Democratic Federation held "to protest against the refusal of the Government to deal with the pressing question of the feeding of school children." Lady Warwick observed that their intention was to help forward the movement for the free maintenance of the children of this country. It was necessary for them all to protest whenever and however they could against the systematic ignoring of what had been agreed upon by the democracy throughout the length and breadth of the land. Mr. H. Quelch moved "that this meeting strongly protests against the refusal of the Government to deal with the pressing question of the feeding of school children by the State, and regards the replies of Mr. Balfour and Sir William Anson to the questions on the subject in the House of Commons as displaying an utter incapacity to recognise the supreme importance of guarding children against the danger of the many diseases arising from underfeeding, and of assuring their development into healthy and vigorous citizens capable of dealing intelligently with the social evils resulting from our capitalist society of to-day. This meeting, therefore, demands that the Government at once take action on the lines of the decision of the last Trade Union Congress at Leeds, the Scottish Trade Union Congress, and the National Labour Conference held at the Guildhall on January 22nd."

Increase of Lunacy.

COUNCILLOR DAVIS, the chairman of the Birmingham lunatic asylums committee of the city council, in a recent address gave some statistics which, although they were selected arbitrarily, may be taken as showing that there has been a 100 per cent. increase of patients suffering from lunacy during the last 40 years in Birmingham. He expressed the opinion that drink was accountable for a greater proportion of the cases of insanity in Birmingham than in England as a whole, and that drink and hereditary influence were respectively accountable in Birmingham during the quinquennial period of 1898-1902 for 17.9 per cent. and 26.8 per cent. of the admissions. He considered that, in view of the large proportion of cases due to the latter cause, something should be done to prevent insane patients having children.

A Lady's Will.

MISS AMELIA JANE BATHURST, of 4, Devonshire Place, Eastbourne, by her will of March 5, 1900, bequeathed £200 to the West London Hospital, Hammersmith; £200 to the Royal Normal School for the Blind, Lower Norwood; and £200 to the Princess Alice Memorial Hospital, Eastbourne.

WE are asked to announce that the Life Saving Society will, by command of His Gracious Majesty the King, in future be styled The Royal Life Saving Society. The Society was established in 1891, and its aims, objects, and work have so appealed to people of all classes, that at the present time it is known not only throughout the United Kingdom but also in the most distant part of the British Empire and Kindred Societies have been formed in Sweden, Italy, and Buenos Aires.

Notices to Correspondents, Short Letters, &c.

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

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 re-forwarding 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.

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.

PROTECTION.—Laws with regard to the selling of remedies do not always fulfil their object. In Austria, the law requires the inventor of a medical preparation to pay a fee and furnish the formula of his preparation, but it is often evaded by sending in a false formula. The moral is that logical administration is a necessary condition of successful laws.

COUNTRY PRACTITIONER.—It would be well to inquire what glasses your village patient uses. Family glasses are regarded and used with the same veneration as prescriptions, and, like these are used for any member of the family who happens to need them. The remote effects of refraction errors upon the nervous system are often little recognised in practice.

MAKING A DIAGNOSIS.

"Your husband, Mrs. Muggleby, is suffering from a complication of diseases," said the doctor. "I must make a diagnosis."
"I hope you can make it of calico, then," was the good soul's reply, "for I haven't a piece of flannel in the house."

GENERAL PRACTITIONER (Leeds).—We are obliged for our correspondent's note. His suggestion shall be duly considered.

DR. M.—The late Mr. Luther Holden was a brother of the Rev. Lonsdale Holden, D.D., for many years head master of Durham Grammar School. The latter is still alive in his 91st year.

WANTED AN OWNER.

It is stated that an American lady, named Quirk, is bringing a singular action against a German surgeon who operated upon her for an abdominal malady. Not finding relief, she placed herself in the hands of a French specialist, who extracted from her body gold-rimmed eye-glasses. It is alleged that the glasses were left there by the German operator, who, however, denies that they belong to him.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MARCH 15th.

ROYAL MICROSCOPICAL SOCIETY (20 Hanover Square, W.).—8 p.m. Lecture.—Mr. J. E. Stead: A Review of the Work done by Metallographers (illustrated by lantern slides).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. P. Paton: Clinique. (Surgical.) 5.15 p.m. Mr. J. Poland: Some Injuries to the Elbow-joint.

CENTRAL LONDON THROAT AND EAR HOSPITAL (Gray's Inn Road, W.C.).—5 p.m. Demonstration:—Dr. Wylie: Naso-Pharynx.

THURSDAY, MARCH 16th.

CHILDHOOD SOCIETY AND THE BRITISH CHILDHOOD STUDY ASSOCIATION (Parkes Museum, Margaret Street, W.).—8 p.m. Lecture:—Miss M. McMillan: Fatigue in Children. (Arranged by the British Child-Study Association.)

ROYAL COLLEGE OF PHYSICIANS OF LONDON (Pall Mall East).—5 p.m. Dr. W. C. Bosanquet: Some Considerations on the Nature of Diabetes Mellitus. (Gouletonian Lecture.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. Hutcheson: Clinique. (Surgical.) 5.15 p.m. Dr. M. Bramwell: Hypnotic Suggestion and its Therapeutic Value.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Lecture:—Mr. W. Edmunds: Intestinal Obstruction.

FRIDAY, MARCH 17th.

EPIDEMIOLOGICAL SOCIETY OF LONDON (11 Chandos Street, Cavendish Square, W.).—8.30 p.m. Paper: Dr. A. E. Boycott: Ankylostomiasis (illustrated by lantern slides).

SOCIETY FOR THE STUDY OF DISEASES IN CHILDREN (11 Chandos Street, W.).—5.30 p.m. Cases will be shown by Dr. O. Grunbaum, Mr. H. Evans, Mr. J. J. Clarke, Mr. S. Stephenson, Dr. G. Carpenter, and Dr. E. Hutchison.

LARYNGOLOGICAL SOCIETY OF LONDON (20 Hanover Square, W.) 2 p.m. Exhibition of Pathological Specimens. 3 p.m. Cases will be shown by Mr. Parker, Dr. Tilley Mr. de Sants, Mr Felix Semon,

Mr. C. J. Symonds, Dr. StClair Thomson, Dr. E. Law, Dr. Milligan, Dr. A. Thorne, Mr. Robinson, Dr. Grant, Dr. Davis, Dr. Lack, Mr. Barwell, and Dr. W. Williams.

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

SATURDAY, MARCH 18th.

LARYNGOLOGICAL SOCIETY OF LONDON (20 Hanover Square, W.).—2 p.m. Demonstration:—Prof. Guuck (Berlin): Method of Removal of the Entire Larynx.

TUESDAY, MARCH 21st.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Mr. Walter Edmunds: Intestinal Obstruction.

Vacancies.

Lincoln County Hospital.—Senior Male House Surgeon. Salary £100 per annum, with board, lodging, and washing. Applications to W. B. Danby Secretary, 2 Bank Street, Lincoln.

Bradford Children's Hospital.—House Surgeon. Salary £100 per annum. Applications to C. V. Woodcock, Secretary.

Herts County Asylum, Hill End, St. Albans.—Junior Assistant Medical Officer.—Salary £150 a year, with board, lodging, and washing. Applications to the Medical Superintendent.

Cumberland and Westmorland Asylum, Garlands, Carlisle.—Junior Assistant Medical Officer. Salary, £130 a year, with board, lodging, and washing. Applications to the Medical Superintendent.

West Riding Asylum, Menston, near Leeds.—Fourth Assistant Medical Officer. Salary £150 per annum, with board and apartments. Applications to the Medical Superintendent.

Assistant Medical Officer for Private Asylum.—Salary £100 per annum, with board.—Applications to Medical Superintendent, The Brook Villa, Liverpool, E.

Assistant Medical Officer for Private Asylum in Ireland. Salary £100 per annum, with board and Residence. Applications to Dr. Osborne, Lindville, Cork.

Municipality of George Town, Penang, S.S.—Assistant to the Municipal Health Officer. Salary £300 a year. Applications to the Dean of the Faculty of Medicine, University of Edinburgh.

St. Mary's Hospital Medical School, Paddington, W.—Curator of Museum and Assistant Pathologist. Salary £100 per annum. Applications to H. A. Caley, M.D., F.R.C.P., Dean.

Glasgow District Asylum, Woodlee, Denzie.—Junior Assistant Medical Officer. Salary £125 per annum, with board, lodging, washing, &c.—Applications to the Medical Superintendent.

Carmarthenshire Infirmary.—Resident Medical Officer. Salary £100 per annum, with furnished apartments, board, attendance, fire, gas, and washing, &c. Applications to Howell Howell, Secretary.

Ayr District Asylum.—Junior Medical Officer. Salary £120 per annum, with board, furnished apartments, attendance, and washing. Applications to the Medical Superintendent.

Bedford County Hospital.—House Surgeon. Salary £100 per annum, with apartments, board and laundry. Applications to W. F. Merley, Secretary.

Appointments.

DAWSON, HENRY KINGS, M.D., B.S., Durh., Public Vaccinator of the Epsom and Ashted Parishes of the Epsom Union.

FARREAST, C., M.B.C.S., L.R.C.P. Lond., Certifying Surgeon under Factory and Workshop Act for the Taunton District of the county of Somerset.

NELSON PHILIP, M.D., Viet., M.D. Liverp., Honorary Assistant Physician and Laryngologist to the Liverpool Chest Hospital.

PATRIDGE, S., M.B. Edin., Certifying Surgeon under the Factory and Workshop Act for the Wednesbury District of the county of Stafford.

ROBERTSON, O. H., L.S.A., Certifying Surgeon under the Factory and Workshop Act for the Osmothery District of the county of York.

Births.

DALY.—On March 13th, at 95 Upper Clapton Road, London, N.E. the wife of Frederick J. P. Daly, M.B.C.S., L.R.C.P., of a daughter.

HAWES.—On March 7th, at Paugbourne, the wife of G. Charles B. Hawes, M.B.C.S., L.R.C.P. Lond., of a son.

Marriages.

FIELDING-OULD—TUSTIN.—On March 7th, at St. George's, Hanover Square, London, Robert Fielding-Ould, M.A., M.D., son of the late R. F. Fielding-Ould, to Edith, widow of the late William Tustin, Esq., of Bray.

Deaths.

ALEXANDER.—On March 9th, Maud, wife of Thomas Anderson Alexander, M.D., Epsom, Surrey, and third daughter of the late Mr. Charles Frederick Murray, in her 41st year.

HOLMAN.—On March 18th, at 3 Roselyn Court, Hampstead, Lucy E. S. Holman, widow of the late W. H. Holman, M.B.

STRELL-PERRINS.—On March 7th, at 56, Pennsylvania, Exeter, Samuel Steele-Perrins, M.D., aged 86.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXX.

WEDNESDAY, MARCH 22, 1905.

No. 12.

Original Communications.

PNEUMONIA IN PREGNANCY.

By H. C. DRURY, M.D.,

Physician to Sir P. Dun's Hospital, Dublin. (a)

PNEUMONIA in pregnancy is stated to be rare. Acute lobar pneumonia "is one of the most widely extended as well as one of the most fatal diseases." (West.) By far the largest proportion of cases occur within the ages which coincide with the child-bearing period of life. But although men are attacked more frequently than women in the proportion of two or three to one, it is sufficiently common in women to make it surprising to find that pneumonia as a complication of pregnancy is rare. Though I have met with a very large number of cases of pneumonia, I may consider myself fortunate in having seen three cases occurring in pregnant women. It is difficult to find records of such cases, and references by various writers on this subject are very vague and general. Grisolle collected fifteen cases (*Archiv. gen. de Med.*, vol. xiii, p. 291), which is the largest number I have been able to find.

In such a dangerous disease as pneumonia, which is said to account for 12.7 per cent. of all the deaths from purely medical diseases (West), one would expect that when it attacked a pregnant woman the case was well-nigh hopeless. This is indeed the view mostly held by writers, though they, as a rule, give but vague and indefinite reasons for their faith. Moore ("Ency. Med.," vol. ix, p. 446) considers that one reason for the greater mortality of pneumonia among women than in men is that pregnancy adds immensely to its danger. The statistics of St. Bartholomew's Hospital, however, throw doubt on this supposed higher relative mortality in women. West's statistics show a percentage of 23.5 for men and 22.0 for women, and the statistics of St. Thomas's Hospital show 21.4 for men, and 16.3 for women. Grisolle's fifteen cases would tend to support the idea that pneumonia is very fatal in pregnancy, for eleven of those fifteen cases died; but West, who seems to be little influenced by general statements, preferring to depend on his own observation and accurate statistics, says: "Pneumonia but rarely arises in the course of pregnancy, but when it does it usually causes abortion, and the child is lost. The mother, however, frequently escapes." (P. 298.)

Pneumonia is just the class of febrile disease in

which we would expect premature expulsion of the foetus, for here we have, as a rule, a high range of temperature which is rapidly attained, and may as rapidly fall; severe constitutional disturbance and great respiratory embarrassment, with probable cyanosis. Any one of these conditions we know is liable to bring about the death or premature expulsion of the foetus, but when combined they are almost certain to do so.

As in other febrile states, labour is usually rapid and easy; in fact, it is recognised by midwifery authorities that in these conditions "precipitate labour often occurs." It is necessary for the patient that there should not be undue delay, and if there is marked dyspnoea, cyanosis or symptoms of a failing heart, steps must be taken to aid and hasten the labour. The relief of abdominal pressure and the hæmorrhage consequent on labour appear to be beneficial in easing the respiration and relieving the engorgement of the right side of the heart, so that when labour has been safely accomplished, the patient is considerably relieved, and sleep—the thing most frequently wanting, the most difficult to obtain, and the most beneficial when it occurs—is obtained. The puerperal state should be managed precisely as in any normal case, and there is no increased risk of sepsis. The pneumonic condition must be treated as though pregnancy was not present. Stimulants will probably be required, but should be withheld if possible till the time of labour. At this time the hypodermic injection of strychnine and the administration of digitalis, or digitalin, may also be required if there are signs of heart failure, and oxygen may possibly be of some slight value when there is marked cyanosis. If there is engorgement of the right side of the heart, venesection to 20 or 30 ounces gives some relief.

The cases I have met with are briefly as follow:

Case I.—J. D., æt. 22, primipara, in seventh month of pregnancy, came under observation on the sixth day of disease, and was found to have pneumonia of the whole upper lobe of the right lung. She was an anæmic girl and appeared desperately ill, with orthopnoea and an expression of intense anxiety and suffering, but no cyanosis; the pulse 128, temperature 103.4° F. and respiration 28 in the morning and 40 in the evening. During the night of the seventh day there was an attempt at—or pseudo—crisis, the temperature falling 3.4°, but she was found to have developed pneumonia of the left upper lobe. The next evening the temperature had reached 103.6°, and premature labour came on during the night; it was easy, rapid and normal; the child was dead,

(a) Paper read in the Section of Medicine, Royal Academy of Medicine in Ireland, March 3rd, 1905.

but apparently quite recently so. The morning after labour—eighth day—the temperature fell to 98.4°, but soon rose again, and came finally down to normal on the fourteenth day. Convalescence was now rapid and uninterrupted. After delivery, though still suffering from active pneumonia of the left apex and unresolved pneumonia of the right apex, she expressed herself as “feeling grand.” Her pulse never rose above 102, her breathing was easy and not distressed, and she slept most of the day and night.

Case II.—L. O’C., 3-para., in seventh month, æt. 32; labour in both previous confinements said to be very short and easy.

She was admitted to hospital on the fourth day of illness. There was then well-marked pneumonia of right base and fine crepitation at left base; temperature 103°, pulse 120, respiration 24. She was very sick, but did not appear in a dangerous condition. By the sixth day there was well-marked pneumonia of left base, and that night there was a pseudo-crisis, the temperature falling to 98.2°, but other symptoms not abating. On the night of the seventh day she was confined. The labour was easy and very rapid; there was practically no pain. The child was alive, obviously premature, but only lived eleven hours. Patient appeared very easy when seen next morning, and she slept plentifully. Genuine crisis occurred on the night of the eighth day—*i.e.*, seven days after the pneumonia attacked the left base. She made a rapid and uninterrupted recovery, and was up for an hour on the fifteenth day.

Case III.—E. N., æt. 28, 6-para., eight months pregnant. Admitted on fifth day of illness, and found to be suffering from pneumonia of lower lobe of right lung. Condition good; temperature moderate, pulse quiet and of good quality; respirations hurried, but not distressing. These conditions were maintained, and she slept fairly well. Movements of the child were felt on the seventh day. Early on the morning of the eighth day labour came on; it was easy, brief, and quite normal. The child was premature, and just alive when born, but died immediately after. When seen four hours after, the patient was comfortable and easy. Next morning she was noticed to speak rather strangely about her home, and warning instructions were given to watch her closely. Very soon she became wildly delirious, and remained so for six days. Whether this was ordinary febrile or post-febrile delirium, or mania of the puerperal type, it is difficult to say. The temperature, which had rapidly fallen to normal on the ninth day, ran up on the three successive evenings, falling each morning to normal or subnormal, but from the thirteenth day it remained normal. This latter febrile condition was evidently in some way due to the disturbance of the delirium, as the pneumonic lung began at once and continued to resolve after the ninth day, and the uterine conditions were quite satisfactory. After the week of delirium she seemed quite well, after another week was allowed up, and left perfectly well.

These three cases do not give one sufficient grounds for drawing important conclusions; the fallacy of doing so is seen in the fact that all three were in seventh or eighth month of pregnancy; yet no one would surely suppose that this was the likely period for a woman to be attacked. We have seen inferences drawn, however, from just as absurd bases. Yet there are one or two points illustrated which tend to bear out what we said

in introduction. First, it is not necessarily such a deadly complication as some writers would have us believe. Two were cases of double pneumonia—a sufficiently grave condition in itself—but one of these was in addition double apical pneumonia. Yet all three, though profoundly ill, never appeared in immediate danger, and their recovery bears out West’s remark that “the mother frequently escapes.”

In all, premature delivery occurred, which appears to be the usual course of events. Delivery having been safely accomplished, the patient’s condition appeared to be materially improved, all the symptoms, temperature, pulse and respiration, being lower. Delivery was rapid and easy in each case, which appears, for some reason, to be the rule in labour during febrile conditions, perhaps due to the softening and relaxation of the genital passages as a result of the high temperature. There was no additional trouble in the management of the puerperal state, the lochia were normal, and had no special tendency to become septic; the breasts gave no trouble, as the secretion was to a large extent checked by the fever.

The three children succumbed, but though premature, they were alive up to the time of birth, and if they had been nearer maturity might have survived, one having lived eleven hours.

AMBIDEXTERITY :

OR, THE POWER OF USING EITHER HAND WITH AS MUCH EASE, FREEDOM AND STRENGTH AS THE OTHER CAN BE USED. (a)

By SIR JAMES SAWYER, M.D., F.R.C.P.,
Senior Consulting Physician to the Queen’s Hospital,
Birmingham.

MAN is not by necessity unidextral. He enjoyed ambidexterity early in his development and lost it in his later culture, especially in his fighting and in his handwriting. Man became right-handed in his fighting because he needed his left hand to shield his heart, and because he found that a weapon of offence which could be wielded by one hand was superior to one which needed both his hands, because he was better off with one hand free to shield his heart or to seize his enemy.

Each of us may regain ambidexterity, that is, the full use of each hand. Perhaps we cannot help having a preferred hand, but we can help having a neglected one. If we are right-handed, as most of us are, we can educate our left hands, especially in one-handed work, until we reach ambidexterity. If we are left-handed, as a small proportion of people are, we should not try to become right-handed, but we should not neglect our right hands, and we should educate them until ambidexterity be attained. With each of us there will always be some innate prompting to the habitual preference of one hand. We should try to make the neglected hand as equal to the preferred hand as possible. Each of us may attain ambidexterity by forming the habit of using each of our hands in turn in our one-handed activities. In a few months we may attain to fair ambidexterity, in a few years to the full use of each hand. For this object the best exercise is writing with the neglected hand. If a man learn to write well with either hand, almost all other uni-manual graces will be added unto him. Changing the hand holding the pen in writing will be found a great help in

(a) Abstract of a Lecture delivered on March 2nd, 1905, before the Ambidextral Society of London.

a large correspondence by letter-writing, and it is especially restful to those who must write a large number of letters daily with their own hands. There are many other uni-manual activities in which, by changing the hand employed in them, we may cultivate ambidexterity, as in carrying a stick or umbrella, in fencing with a foil, in counting money, in changing our watch pocket from side to side, in changing the parting of our hair, in the use of a spoon in taking soup, in domestic carpentry, as in many other usual activities. There is a great deal of character in handwriting. Each hand has its own scriptorial characteristics. If these characteristics reveal character, then the revelations of character by handwriting are not complete unless we have the writing of each hand for our examination. As to what is called graphology, the revelations of personal characteristics by handwriting, there is something in it. The subject seems to have been pursued upon a scientific basis in France. The utilities of ambidexterity as to various industrial manual activities are manifold. It is restful and otherwise useful, as in reaching places with one hand which are difficult of access to the other; to house painters, to carpenters, to surgeons, and to many other varieties of workers, and certainly to physicians. An ambidextrous physician never feels on the wrong side of his patient, and he will find his ambidexterity useful in his arts of percussion, palpation, laryngoscopy, ophthalmoscopy, and in many other of his manual duties. Ambidexterity is of striking use when injury or disease has impaired or destroyed the writing power of the preferred hand. Ambidexterity is of remedial use in the disease known as scrivener's palsy or writer's cramp, a disease in which there is a morbid excitement of the nerves ruling the muscles of the fingers and thumb habitually used in holding a pen in writing, resulting in cramps which completely prevent writing, so that the condition becomes in effect a local paralysis. Ambidextral writing may prevent the occurrence of this disease. Whenever the disease has declared itself, complete rest of the affected muscles is an inseparable condition of successful treatment. As to this writer's palsy, ambidexterity is certainly preventive. It is possibly preventive also of some forms of brain disease, such as apoplexy from the breaking of a blood-vessel, by distributing the "wear and tear" of brain activity over a wider area than when only one hand is employed. In my view, ambidexterity as to handwriting should be taught in all schools, and it should be required by examination for certificates of fitness in many employments, certainly for members of the medical profession. The nerves which rule the right upper extremity come from and go to the left side of the brain, and those which rule the left upper extremity come from and go to the right side of the brain. We have not two brains, but our brain is largely and in large part dual, that is, a great part of our brain is divided into two matching and symmetrical halves, either of which can act independently of and in turn with the other, and either of which halves can do and perform each of the functions and activities of the other, excepting in the case of speech. Our speech "centre" is on the left side of our brain; certainly it is on that side in right-handed persons. Perhaps we have only to become ambidextrous to dualise our speech

centres, so that we might have one on each side of the brain, instead of on one side only, and so that loss of speech from disease on one side of the brain would cease to be.

THE CHOICE OF TREATMENT FOR FIBRO-MYOMA OF THE UTERUS. (a)

By J. INGLIS PARSONS, M.D., M.R.C.P.,
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ON account of the great variety in the size and position of these tumours, and the difference in the symptoms and age of patients, the question was discussed under seven headings. Cases were described to illustrate the different operations and methods of treatment.

FIRST GROUP.—"Tumours producing no symptoms."—Medical and hygienic measures were advocated to try and stop the growth, and so prevent symptoms coming on later. Operation was not considered justifiable in these cases.

SECOND GROUP.—"Small tumours causing severe menorrhagia without pressure symptoms."—If menorrhagia and pain could be abolished in these patients, they were restored to health. In 95 per cent. electricity would achieve this, and ought to be tried before operation, so that the patient could still bear children.

THIRD GROUP.—"Small tumours producing pressure symptoms, with or without menorrhagia."—When the pressure is produced by retroversion the uterus can be kept in position by a Hodge pessary, and electricity used. If the pressure is on the bladder, operation is necessary, either myomectomy or hysterectomy, or removal of the appendages.

FOURTH GROUP.—"Uniform enlargement resembling that of pregnancy at four to six months in shape, and causing pain and metrorrhagia."—Operation was recommended for this group, because of the pressure symptoms. For those who declined operation, electricity was of great value, as it generally got rid of the symptoms for some years, and could be repeated if necessary.

FIFTH GROUP.—"Tumours forming a round mass confined to the pelvis, and sometimes impacted."—These should be operated on as soon as possible, because the pressure of the tumours on the bladder, ureters and bowel soon caused depreciation of the general health, and delay increased the risk.

SIXTH GROUP.—"Very large tumours filling the abdomen, the size of a full-term pregnancy."—He did not advise electricity in these cases, although he had known it do good, because the diffusion of the current over a large mass was less effective than in smaller tumours. Hysterectomy was sometimes difficult, especially when there were many adhesions, but it is the only available treatment.

SEVENTH GROUP.—"The relation of the menopause to fibroid tumours."—The menopause comes on much later with fibromata, very often not occurring until after fifty. As a rule the tumours cease to grow and become smaller. The diminution is greater in the small tumours than in the

(a) Abstract of Paper read at the Meeting of the British Gynaecological Society, March 9th, 1905.

large. The number of cases where the tumours continue to grow after the menopause forms only a small percentage. He gave notes of three cases treated by electricity which he had watched for 17 years, 14 years, and 9 years respectively, and who had gone through the menopause and kept well without operation.

THE DEVELOPMENT OF DIAGNOSIS AND TREATMENT OF URINARY DISEASES

DURING THE LAST TWENTY-FIVE YEARS. (a)

By DR. H. WOSSIDLO,
Of Berlin.

SPECIALLY REPORTED FOR "THE MEDICAL PRESS AND CIRCULAR."

In choosing for to-night's paper "The Development of the Diagnosis and Treatment of Urinary Diseases During the Last Twenty-five Years," I am fully aware of the difficulties I have to deal with. It will be impossible to go into details, and I must be content to confine myself to the more prominent points.

It is to Nitze and his invention of the cystoscope we owe in the first place the progress we have made. The cystoscope has thrown light on the previously obscure diseases of the bladder and kidney. But in giving cystoscopy the first place in the acquisitions made in genito-urinary surgery, I do not mean to under-estimate the many other inventions and discoveries made during our period. The bacteriological, chemical, physiological, and pathological researches of Koch, Neisser, Bumm, Wertheim, Albarran, Roosing, Koranyi, and many others have just as much added to our present knowledge.

In proportion to the improvement of our diagnosis, the treatment of urinary diseases, especially genito-urinary surgery, has greatly advanced. I need only mention the names of Israel, Küster, Kummell, Guyon, Albarran, Thompson, Harrison, Otis, Fuller, Kelly, and others to recall to your memory a great many operations which have marked an epoch in genito-urinary surgery.

After these short introductory remarks, I will discuss the progress made in the diagnosis and treatment of the diseases of the various organs.

I.—DISEASES OF THE URETHRA: GONORRHOEA AND URETHRAL STRICTURE.

It is a strange coincidence that in the same year, in 1879, when Nitze demonstrated his cystoscope for the first time before a large medical audience, Neisser discovered the gonococcus. We all know that this discovery of the gonococcus has overthrown all previous theories with regard to the nature of gonorrhoea. Upon the discovery of the gonococcus by Neisser, and upon the confirmation of its specific nature by the bacteriological experiments of Bumm, Finger, Wertheim, and others, the diagnostic value of the gonococcus in the urethral secretion is founded. The diagnosis of *acute gonorrhoea* has since then been solely based upon the detection of the gonococcus in the urethral secretion.

The discovery of the gonococcus has led to the modern antiseptic treatment of acute gonorrhoeal urethritis. It has been the principal aim of Neisser and his followers to find new antiseptics which would destroy the gonococcus as quickly as possible. Although an absolutely sure specific treatment of acute gonorrhoeal urethritis has not yet been found, the therapeutical results obtained by the modern antiseptic treatment can be considered a great advance.

Let me draw your attention to the new method of prophylaxis for acute gonorrhoea. It is an undeniable fact that the introduction and the use of the modern antiseptics, especially the organic silver salts, as preventives of gonorrhoea, have considerably lessened the danger of gonorrhoeal infection. By the application of

the so-called "prophylactol," consisting of a 20 per cent. solution of protargol in glycerine, or of some of the other prophylactics, immediately after coition, infection with gonococci can in a great many cases be prevented. Generally speaking, we must admit that since the introduction of modern antiseptics acute gonorrhoeal urethritis runs, in the majority of cases, a much milder course than before, although the new drugs have not entirely fulfilled all the expectations their inventors had hoped for.

The progress made in the diagnosis and treatment of *chronic gonorrhoea* is chiefly due to urethroscopy and to the histological researches of Neelsen and Finger.

Of course, urethral endoscopy itself is not an invention of these last twenty-five years, since the first endoscope was constructed by Desormeaux in 1853; but the great improvement that endoscopes have undergone during the last twenty-five years has led to the present standard of urethroscopic diagnosis and treatment of chronic urethritis. It would be unjust to omit the merits of Grünfeld, of Vienna, with regard to urethral endoscopy, but the recent progress made in urethroscopy dates to a great extent from the introduction of electric light into medical science.

We divide the modern urethroscopes into two classes, those with reflected and those with direct light. To the former belong the panelestroscope of Leiter, the endoscopes of Casper, Görl, Lang, and the aëro-urethroscopy of Anbal. The urethroscope with direct light is the so-called Nitze-Oberlaender urethroscope, which was invented by Nitze in 1877, and improved by Oberlaender. Its source of illumination is a platinum wire which, being fixed in the distal end of the cannula, is introduced into the urethra to illuminate a given area of the surface of that canal. To prevent the platinum wire from getting hot, the shaft of the urethroscope is traversed by canals in which cold water circulates.

In 1899, Valentine, of New York, made an important improvement on the Nitze-Oberlaender urethroscope by replacing the platinum wire by a small Edison lamp. On account of the little heat produced by the Valentine lamp the water-cooling apparatus can be done away with, which in a way hampered the use of the Nitze-Oberlaender urethroscope.

Neelsen and Finger have shown that the histological process in chronic gonorrhoeal urethritis consists in an infiltration of the urethral mucosa with round, mononuclear cells, which gradually change into connective tissue, and finally result in organised fibrous tissue. They have further found that this infiltration has a tendency to limit itself to circumscribed areas, especially around the urethral glands, and that these glands themselves are affected. With the help of his urethroscope, Oberlaender, of Dresden, has taught us to diagnose these alterations of the urethral mucosa, *i.e.*, the various degrees of infiltration and the glandular inflammation. Upon his urethroscopic studies Oberlaender has based his treatment of chronic gonorrhoeal urethritis by dilatation.

To a certain extent, dilatation treatment had already been used before Oberlaender practised it. You all know the treatment of chronic gleet with elastic bougies and metal sounds. This treatment, however, was entirely empirical, and was principally used to prevent the narrowing of the urethral canal, which usually is a sequel of a non-cured gleet. Oberlaender's dilatation treatment, on the contrary, is based upon an exact urethroscopical diagnosis. We not only know now when we have to commence with dilatations, but we can, with the aid of the urethroscope, exactly fix the parts of the urethral canal which have to be dilated, and consequently select the instrument suitable in a given case. At the same time we are able to control the results of our treatment by ocular inspection.

The experience of the last twenty-five years has taught us that to obtain a cure of chronic gonorrhoeal urethritis in the majority of cases dilatation has to be carried to a much higher degree than is possible by using urethral sounds, which soon find their limit in the narrowness of the external urethral orifice. For this

(a) A Paper read at the Meeting of the Anglo-American Medical Society in Berlin.

reason Oberlaender constructed special dilators, the Otis dilating urethrotome being the pattern. These dilators are composed of two steel branches applied one against the other. When closed they have the form of a metal sound and a calibre corresponding to No. 15 Charrière. By an arrangement of hinges and a screw the two branches can be separated at will up to No. 40 Charrière. Kollmann, of Leipzig, has modified these dilators in giving them four branches instead of two.

In comparing the results of the dilatation treatment of Oberlaender with the former treatment by bougies and sounds, we can without exaggeration say that the percentage of complete cures of chronic gleet has considerably increased during the last twenty-five years. Of course, this dilatation treatment has its limits as well, the ideal cure of all cases of chronic gonorrhœal urethritis not having yet been attained. I even doubt if this will ever be possible, many other influences playing a prominent part in preventing a complete cure, which influences are quite beyond our control.

The urethroscope, furthermore, enables us to apply some other local treatment to the urethral mucosa—electrolytic destruction of diseased urethral glands, cauterisation, &c.

Before finishing this part of my paper I wish to draw your attention to the progress made in the prevention of gonorrhœal infection of the female by the discovery of the gonococcus and by urethroscopy. The microscopical and bacteriological examination of the urethral secretion, as well as urethroscopy, have given us the indication when we are to give our consent to the marriage of a man who has had gonorrhœa, and when we ought to withhold it.

The progress made in the diagnosis and treatment of urethral stricture during our period has not been so great. The diagnosis of stricture is still based upon the symptoms and upon the examination of the urethral canal with sounds, especially with the bougie à boule. There is a difference of opinion with regard to the term "stricture," the stricture of large calibre of Otis' teaching being more generally recognised nowadays than it used to be before, when one spoke of a stricture only in those cases of narrowing of the urethral canal which caused more or less serious disturbances of micturition. Especially has urethroscopy shown us the frequency of these strictures of large calibre.

The present treatment of urethral stricture still consists, as before, in gradual dilatation with sounds, in continuous dilatation with a sonde à demeure, in internal and external urethrotomy and in electrolysis, although the instruments and methods have been modified and improved.

You will find in the older surgical text-books that a stricture is considered to be cured if a metallic sound, No. 18-22 Charrière, can be introduced. Nowadays we aim at a much higher degree of dilatation, trying to reach at least No. 28-30 Charrière. In a paper read before the Berliner medicinische Gesellschaft in 1895, I have already advocated these dilatations of urethral strictures, and have demonstrated the possibility of curing a great many in that way without danger of a future relapse.

II.—DISEASES OF THE PROSTATE: PROSTATITIS AND HYPERTROPHY OF THE PROSTATE.

During the last twenty-five years much attention has been paid to the diseases of the prostate.

First of all, gonorrhœal prostatitis, its frequency and importance as a complication of gonorrhœal urethritis, has been properly appreciated, so that to-day it has become a rule that in every case of posterior urethritis the prostate should be examined. We have learnt that a great many cases of posterior urethritis are complicated with an inflammation of the prostate.

Instead of relying on the symptoms and upon rectal palpation of the prostate only, we have learned to appreciate the value of microscopical examination of the prostatic secretion obtained by gentle massage of the gland. Gonococci having been found in these cases in the prostatic secretion, first by Neisser and Putzler, it has become a necessity nowadays to determine their

presence or absence before giving our consent to the marriage of the patient.

For the treatment of prostatitis several very useful drugs have been recommended, of which I only wish to mention rectal suppositories and rectal injections of ichthyol, iodoform, belladonna, &c. The application of hot water in the form of hip-baths or rectal injections, as recommended by Guyon, Reclus, and myself, has proved to be very useful in all cases of prostatitis. In 1892 and 1893, Neumann, Schlifka, and von Schlen recommended massage of the prostate in all cases of chronic prostatitis. As long as it is not overdone and is not applied indiscriminately, massage of the prostate has been found a very valuable and effective therapeutic agent.

After a long-lasting gonorrhœa, especially when complicated with prostatitis, a great many local nervous troubles remain. Burckhardt, of Basel, found a chronic swelling of the caput gallinaginis to be frequently the cause of these nervous troubles. I have described them in my book, "On Gonorrhœa of the Male," Berlin, 1903, and have mentioned therein the good results I have obtained by local applications of caustics to the caput gallinaginis under urethroscopic control.

Hypertrophy of the prostate has lately been the subject of greatest interest to genito-urinary surgeons. Undoubtedly the diagnosis of an enlarged prostate by rectal palpation and methodical examination with catheter and sound is in the majority of cases an easy one. It has, however, been brought to perfection by the invention of the cystoscope. Cystoscopy enables us to diagnose in the most exact manner and in the surest way all forms of prostatic enlargement, the cystoscopic pictures being typical and pathognomonic.

The most characteristic changes are found at the internal orifice. Normally, the sphincter internus appears through the cystoscope as a crescentic fold, blood-red in colour from the transmission of the rays of light through its vascular substance. The edge of this fold is even and straight, or it has a more semi-lunar form. In withdrawing the cystoscope we see this fold hanging like a partly lifted curtain before the interior of the bladder.

In prostatic hypertrophy this fold shows marked alterations. In the milder cases its edge has lost its smoothness, and appears uneven and rough. In cases of a more advanced symmetrical hypertrophy of both lateral lobes, instead of the smooth and even fold two symmetrical tumours are visible, leaving a gaping space between them. The sphincter internus appears in the shape of a doorway, or it resembles two hills enclosing a deep valley. In an asymmetrical hypertrophy of the lateral lobes the cystoscope shows us on one side a larger uneven tumour bulging into the field of vision.

Whilst a middle lobe can be diagnosed with the sound only, if it has reached a certain size, the smaller growths, especially small bars running across between the two lateral lobes, mostly escape detection, but the cystoscope will bring them into full view. In turning the beak of the cystoscope downwards we see the middle lobe as a more or less prominent protuberance. The cystoscope at the same time reveals the alterations which the bladder-wall itself has undergone. Trabeculæ formed by the hypertrophied vesical muscles, diverticula and saccules, cystic alterations of the mucosa, as well as many co-existing complications of the ureters or kidneys, can at once be diagnosed. Stones lying in a pouch behind the enlarged prostate will be seen through the cystoscope, whilst they frequently escape detection with the sound.

In this way cystoscopy has considerably improved our previous methods of diagnosis.

The treatment of prostatic hypertrophy, especially its radical cure, has, during these last twenty-five years, taken a prominent part in genito-urinary surgery.

Omitting the dangerous and useless attempts to cure the disease by intra-glandular injections, faradic and constant current electrolysis, three methods have lately occupied the attention of the profession, i.e., the sexual operation, the operation of Bottini, and prostatectomy.

Since Ramon, of Christiania, and White, of Philadelphia, suggested *castration* as an indirect means of reducing the size of the enlarged prostate, the method has received an extensive trial. Statistical compilations were made by White himself of 111 cases, and by Cabot, of Boston, of 99 additional cases, which showed encouraging results. During the years 1893-1897, genital operations for prostatic hypertrophy became quite popular. First double castration was performed; later on, this having been considered too dangerous for old men, single castration, vasectomy, and angio-neurectomy followed. We find in literature many observations of reliable authors showing the good result of the genital operations. The patients began to void urine in a natural way, catheterisation was less difficult and less painful, the residual urine diminished, and the prostate gland was found to be reduced in size and shrunken. But in the majority of cases the apparent amelioration was only of short duration. It was mostly due to the relief of congestion, a result we just as well observe after regular catheterisations. For this reason and on account of the comparatively high mortality and of the not infrequent mental disturbances following genital operations, this method has of late been more or less abandoned.

In 1874, Bottini recommended for the first time *galvano-caustic incision* of the enlarged prostate. In spite of his remarkably good results the operation did not become popular until, in 1897, it was revived by Freudenberg, who modified the original instrument and improved the *technique* of the operation. Since then the method has gained many ardent supporters in Germany and in America. Although the galvano-caustic incision of Bottini can hardly be called a radical operation for hypertrophy of the prostate, yet its results with regard to the restoration of easy micturition in cases of urinary retention are decidedly most favourable. The views of those surgeons whose experience has been extensive, as, for instance, of Freudenberg, Horwitz, and Meyer, agree in the opinion that Bottini's operation is the safest and most satisfactory and at the same time more generally applicable to the different forms of prostatic enlargement than any other method of treatment. Fully admitting the excellent results obtained by this method, in my opinion, and according to my experience, which agrees with that of many other writers, the value of the operation has been somewhat over-rated by its most ardent supporters. In general, the statistics give the following results: Restoration or amelioration of the bladder functions in 73 to 77 per cent., negative result in 14 to 18 per cent. of the cases and a mortality of 7 to 10 per cent.

Various authors have taken exception to this operation on the ground that, as the work is done entirely in the dark, it is a dangerous one to perform. For this reason I have constructed an instrument which combines the galvano-caustic incisor with a cystoscope. Bierkof and Freudenberg still later devised another cystoscopic incisor. Although I have been successful in completing the operation under the control of the eye with my instrument, I have now dropped it, as the *technique* of the Bottini operation with the original galvano-caustic incisor has been made easier and surer. As far as I know Freudenberg has also used his cystoscopic incisor only in a few cases.

That the Bottini operation is not free from danger is shown by the more or less severe complications, as hæmorrhage, acute sepsis, thrombo-phlebitis of the prostatic veins, abscess of the prostate gland, epididymitis, and orchitis, which have been observed in various instances. In some cases the operation is followed by acute retention of urine; in others, by incontinence; both of them generally passing off quickly. The immediate good effect of the operation does not always prevent relapses, but the operation, being a comparatively safe one, can be repeated if necessary.

Two methods for the radical operation on enlarged prostate have lately gained much ground, *perineal* and *suprapubic prostatectomy*.

The beneficial influence upon the troubles of micturition observed after the accidental removal of prostatic lobes in cases of lithotomy has induced several authors—Fergusson, Bryant, Landerer—to perform a perineal incision of parts of the prostate. During the last twenty-five years, perineal prostatectomy has been practised to a greater extent. Since Albarran published his good results, having operated in 42 cases with only one death, the operation has been advocated by various French authors. Young, of Baltimore, has recently modified Albarran's and Proust's method in a practical way, and has successfully operated in 37 cases. He reports 150 cases of operations on enlarged prostates; 85 cases were operated on by the Bottini method with 6 deaths; in 16 cases of suprapubic prostatectomy he had 3 fatal results, whilst all his 37 perineal prostatectomies were successful.

The first suprapubic prostatectomy was done by Amussat in 1834, who removed an enlarged middle lobe in a case of suprapubic lithotomy. But it is to McGill, who published in 1889 a series of cases, that suprapubic prostatectomy mainly owes its progress. The results of this operation have not been extraordinarily good ones. According to statistics made by Burckhardt, of Basel, in 1902, of 77 cases of uncomplicated suprapubic prostatectomy, 31.1 per cent. showed a permanent restoration, 26 per cent. a considerable amelioration of micturition; in 14.3 per cent. of the cases the complications were cured, but the amelioration of the bladder function was only temporary; in 7.8 per cent. the result was negative; 20.8 per cent. ended fatally.

In a case with a very large middle lobe, I have performed suprapubic prostatectomy with permanent good result after Bottini's operation had failed.

Several authors have combined the perineal and the suprapubic operation, as, for instance, Nicoll, Alexander, and others. All the foregoing cases were partial prostatectomies, especially of the middle lobe.

In 1895, Fuller enucleated the entire prostate through a suprapubic incision, the other hand pushing up the prostate from the perineum. After the enucleation of the prostate he placed a drainage-tube through a perineal incision into the bladder. He reported 27 successful cases and had a mortality of 18.5 per cent. Watson, Southam, Forbes, and Hawkes have also published successful cases operated on in the same way. These operations were the precedents of Freyer's (of London) method of total suprapubic extirpation of the prostate, the forefinger of one hand enucleating the prostate through a suprapubic incision, whilst the forefinger of the other hand introduced into the rectum pushes the gland upwards. From a personal communication I am able to state that Freyer has done total extirpation of the prostate in 114 cases with a mortality of 9 per cent., including all accidental deaths even unconnected with the operation, the real mortality being not more than 4.5 per cent.

As far as I know Freyer's operation has been performed by other surgeons in six cases, three of which were successful and three died.

I have still to mention the operation recommended by Poncet in 1888, called *cystotomy*, consisting in the formation of an artificial vesical fistula for the relief of chronic retentions in prostatics. This is only a palliative operation, and should be confined to those cases in which catheterisation or a radical operation is absolutely impossible.

In spite of the good results of the Bottini operation and of prostatectomy, regular catheterisation is still considered to be the normal treatment of retention from hypertrophy of the prostate. In those cases where catheterisation fails to cure the retention, and in which continually a large amount of residual urine is found, either the Bottini incision or prostatectomy have to be advised.

Before finishing this chapter, I should like to mention the retrograde cystoscope of Schlagintweit, which enables us to examine the whole internal orifice of the bladder.

III.—DISEASES OF THE BLADDER AND KIDNEY.

The great progress we have made in the diagnosis

and treatment of the diseases of the bladder and kidney we owe in the first place to cystoscopy.

Generally speaking the cystoscope has thrown light on all diseases showing the symptoms of *pyuria* and *hæmaturia*. If the bladder be the seat of the trouble the cystoscope reveals to us the characteristic alteration of the bladder-wall. We see the blood oozing from a tumour or from an ulceration of the bladder, or we see the inflamed parts of the mucosa, from which pus is secreted. The source of the bleeding or of the supuration being the ureter or kidney, the cystoscope shows us a healthy bladder, but we see the blood or the pus being projected through the orifice of the ureter.

I will now shortly discuss the diagnostic value of cystoscopy in the different diseases of the bladder.

In *acute cystitis* the mucosa of the bladder, especially in the neighbourhood of the sphincter internus, appears hyperæmic from a dense network of blood-vessels.

In *chronic cystitis* we see a swollen mucosa of greyish colour, or a more or less diffuse hyperæmia. The epithelium appears thickened and desquamated in several places.

Of course, the diagnosis of cystitis can easily be made without the cystoscope, and in acute cystitis cystoscopy will better be avoided. But in any case of doubt as to the cause of the cystitis it should be resorted to.

The diagnosis of *tuberculosis of the bladder* is based upon the symptoms and upon the detection of tubercle bacilli in the sediment of the urine. Every introduction of an instrument into a tuberculous bladder being followed by an aggravation of the symptoms, cystoscopy had better be avoided. Only in those cases of urinary tuberculosis in which we suspect a primary tuberculosis of the kidney, the bladder affection being secondary, cystoscopy should be practised. We then find tuberculous nodules or ulcerations around the orifice of the ureter. In such cases catheterisation of the ureter will confirm our diagnosis, which is of great importance, the experience of the last twenty-five years having taught us that an early nephrectomy may in such cases of descending tuberculosis lead to a cure of the diseased bladder.

The many important bacteriological researches in the above-mentioned diseases of the bladder, which have been made during our period, are sufficiently known, so that I need not go into details. They have considerably added to the present standard of diagnosis.

With regard to the *treatment of cystitis*, the last twenty-five years have brought a good many useful drugs, of which salol, urotropin, and helmitol may be named. In chronic cystitis irrigations of the bladder, especially with nitrate of silver, have maintained their place. For the *treatment of tuberculosis of the bladder*, Guyon has recommended instillations of sublimate and of guaiacol. Subcutaneous injections of tuberculin are highly spoken of, especially in England. Several authorities have tried to cure tuberculosis of the bladder by cauterisation or curretting the ulcers through a suprapubic incision, but the really successful cases are rare, the general opinion being to let a tuberculous bladder alone and to avoid any operation, unless a nephrectomy be indicated, as has already been said.

The *diagnosis of stone in the bladder* has been very much facilitated by cystoscopy. In the majority of cases the examination with the sound will suffice for the detection of a stone, but the cystoscopic diagnosis is a much more certain one, the smallest stones, even gravel lying on the floor of the bladder, being visible through the cystoscope, whilst a good many stones may escape the sound. From the colour, the shape, and the surface of the stone we can differentiate between a phosphatic, uratic, and oxalate stone, and can accordingly make our plan of operation.

Of the operations for stone, *litholapaxy* has, during the last twenty-five years gained more and more ground. Here again the cystoscope has proved to be of the greatest value, permitting us the surest control of the results of the operation. To facilitate the

examination after litholapaxy, Nitze has constructed an evacuating cystoscope, consisting of an evacuating catheter, in which a cystoscope can be fitted.

Previous to the invention of the cystoscope, the *diagnosis of tumours of the bladder* was very uncertain. We solely relied upon the symptoms, upon bimanual palpation, and examination with the sound. The cystoscope, however, shows at once whether the hæmorrhage be caused by a tumour or not. We can distinguish the form of the tumour, if it is pedunculated or has a broad base, and its situation can most accurately be seen and in many cases we can diagnose its anatomical structure, whether benign or malignant. But the greatest gain derived from cystoscopy lies in the possibility of making an early diagnosis of a tumour at a time when all other diagnostic means fail.

With Nitze's operation cystoscope, I have been able to remove a polypus the size of a small hazel-nut, which caused considerable hæmorrhage, and whose diagnosis would have been absolutely impossible without the cystoscope.

In benign growths having a tendency to become malignant the possibility of an early diagnosis by the cystoscope is of the greatest importance, as it should lead to an early operation.

With his operation cystoscope, Nitze has given us the means to remove bladder tumours *per vias naturales* without opening the bladder.

Finally, I have to mention that the discovery of *foreign bodies* in the bladder has been made absolutely sure by cystoscopy.

The great advances *renal surgery* has made during the last twenty-five years we owe to cystoscopy, to catheterisation of the ureters, to the physical examination of the blood and urine, to cryoscopy and to radiography. Whilst formerly the diagnosis of renal diseases was based solely upon the personal experience of the physician, upon palpation of the kidney and examination of the urine, now cystoscopy enables us to make a differential diagnosis between diseases of the bladder and kidney. It being necessary in all renal operations to know the state of the other kidney, endeavours have been made to separate the urine of each kidney. This problem has been solved by *catheterisation of the ureters*, the way this could be accomplished having been indicated by cystoscopy. The first attempts to catheterise the ureter with special cystoscopes were made by Brenner in 1887, Poirier in 1880, and Boisseau and der Rocher in 1892, but this catheterisation became popular only after the construction of the modern ureter-cystoscopes by Nitze, Casper, and Albarran, which give the catheter the necessary curve.

Catheterisation of the ureters not being possible in every case, several efforts have been made to separate the urine of each kidney by a mechanical division of the bladder itself between the two ureters. Neumann, Harris, Downes, Luys, and Cathelin have, for this purpose, constructed their so-called *segregators*. Downes' segregator is intended to divide the bladder into two portions by pushing up the floor of the bladder from the vagina or from the rectum. Luys and Cathelin introduce an instrument of the shape of a metal catheter into the bladder and divide its cavity by expanding a rubber membrane between the ureteral orifices. Although these segregators have in some cases given satisfactory results, yet one cannot rely with absolute certainty upon their exactly separating the urine of each kidney. They will therefore be left for all cases in which catheterisation of the ureters is impossible.

A most important step forward in the diagnosis of kidney diseases has been made by Koranyi's invention of *cryoscopy*, i.e., the diagnosis of the renal function by ascertaining the molecular concentration of the urine and blood. A little later Casper and Richter introduced the *phloridzin test* in the diagnosis of renal diseases.

To these advances in diagnosis, all of which have been made during the last twenty-five years, the splendid results of modern renal surgery have to be attributed, so that Kümmell, of Hamburg, was able to state in

1903 that the mortality of his nephrectomies had decreased from 28 per cent. to 4·8 per cent.

In closing my paper I have to mention another discovery of modern times, *radiography*. Although in cases of stone or foreign bodies of the bladder, radiography remains inferior to cystoscopy, yet it will be useful wherever the latter is impossible. But in all cases of nephro-lithiasis, radiography is of the greatest value, the Röntgen rays permitting the diagnosis of stones in the kidney, which cannot be made by any other means with the same accuracy.

Transactions of Societies.

BRITISH GYNÆCOLOGICAL SOCIETY.
MEETING HELD THURSDAY, MARCH 9TH, 1905.

DR. W. ALEXANDER, President, in the Chair.

SPECIMENS AND CASES.

DR. EDGE showed a specimen of Malignant Adenoma of the Fundus of the Uterus.

This specimen was removed entire from a patient, æt. 62, who had been suffering from sanious discharge for the last two years. I found the body enlarged and freely movable, with a long cervix, the fundus was retroflexed, and the sound passed into it, causing some bleeding and feeling marked roughness of the wall. There was some difficulty in getting the uterus out without bursting the fundus, an accident which often happens in dealing with such cases and which soils the peritoneum and raw wound surfaces. I tied a ligature round the cervix to occlude it after having washed out the uterus with boracic acid solution, and held the os occluded by volsella in the early stages.

2. Malignant Tubo-Ovarian Cyst.

This specimen was successfully removed from a married woman, æt. 44; one child, æt. 12, and two abortions since the child, last 12 months ago. She has seen nothing for two years. She complained of "a large substance at the bottom of the bowels which keeps rising about." The tumour was easily made out and my early diagnosis was myoma or sarcoma of the uterus, as she had a sanguineous discharge after the first visit. Afterwards I could make out the uterus distinctly with the solid cystic growth on the left. This suggested a broad ligament growth. It was found to be a tubo-ovarian, semi-solid, papillomatous cyst, and after separation of adhesions I got it away safely. Professor Leith kindly suggested that it was of exceptional interest as the growth appears to have begun in the tube; at any rate the whole of the tube is studded with growths and the tube and ovary form a continuous cyst wall. The microscopic sections are from the tube and from the ovary, and show that the wall is not perforated or deeply invaded, and consequently that, although the growth is of a highly malignant nature, yet since it is everywhere contained, a permanent cure is to be expected. The microscopic section shows that the uterine wall has not been perforated by the growth, and in this case also it is to be hoped that a permanent cure may be effected.

3. Uterus removed for Metrorrhagia:—

The specimen of uterus removed for metrorrhagia was unfortunately thrown away. The interest in the case was that the metrorrhagia was so severe that I removed the uterus for that symptom, although I could not detect any distinct tumour, and considered the case one of hæmorrhagic metritis. However, on removal there was found a submucous myoma at the very fundus which elongated the uterus one inch, but which was so completely in alignment with the uterus that palpation did not recognise it. It is possible that examination under an anæsthetic would have rendered its detection possible, as it was so hard and different in feel from the uterine tissue. Also perhaps the difference between the size of the uterus and the distance to which a sound passed might have attracted notice.

4. Uterus removed for Procidencia:—

The specimen of elongated uterus is from a case of prolapse with ulceration of the vaginal wall. The patient was not relieved by instruments, and being past the change I removed the uterus and sutured the fasciæ across. The posterior vaginal wall was divided mesially, thus facilitating hæmostasis, and allowing the recto-vaginal visceral layer of pelvic fascia to be reduplicated. It also permits the exact closure of the anterior portions of the wound with drainage of the lowest portion of the pouch of Douglas, and may be of use in complete removal of the uterus and vaginal walls to prevent the deep suppuration so often present. It does not weaken the pelvic floor because it is at right angles to the axis of the pelvis.

DR. MACNAUGHTON-JONES remarked that in hæmorrhagic endometritis, if they had not the results of careful microscopic examination and the history of the case, they were absolutely in the dark. He thought that if the uterus were not removed at once, it should be curetted in order to ascertain what is the nature of the change causing the hæmorrhage.

DR. R. BELL said the curette was a useful instrument, but in hands not accustomed to its use it was very dangerous, and he would not be at all surprised that malignant uterine disease had been set up by the employment of the curette in cases where the disease had not been malignant. In reference to the tumour which Dr. Edge had brought before the Society, he (Dr. Bell) considered that the treatment was very effectual.

DR. MACNAUGHTON-JONES said he entirely disagreed with Dr. Bell. Curetting could hardly be called a dangerous operation. Certainly in ignorant hands the curette might be pushed through the uterine wall, but that was unlikely to occur in an operation performed by any experienced gynæcologist.

DR. J. INGLIS PARSONS said that in cases of metrorrhagia, his rule was to examine the uterus thoroughly under an anæsthetic, and even if any tumour were present, if the appendages were normal, he gave the patient a chance of curetting before hysterectomy.

DR. MACPHERSON LAWRIE said he was rather surprised at Dr. Bell's protest. In the whole range of gynæcology there was no more useful operation than curetting, it was an operation practically devoid of danger, and he thought Dr. Bell would find it exceedingly difficult to prove that curetting of the uterus had ever led to a malignant condition of the ovaries.

DR. EDGE, in reply, said he did not think curetting would have helped him in the case of malignant adenoma. The only way to discover the myoma in the fundus would have been to open the abdomen, but he considered that vaginal hysterectomy after the uterus had ceased to serve any natural function was much safer and more suitable than opening the abdomen without any reason to expect to find a myoma capable of enucleation. He rather agreed with what Dr. Bell had said with regard to curetting, but not altogether for the same reasons. In the case of cancer of the fundus he had shown, there was a good thickness of wall. Luckily the growth had been centripetal instead of through the wall, and probably curetting would not have done any harm. As to the question of examination under an anæsthetic, he thought a good time to do that was before the operation.

DR. J. INGLIS PARSONS read a paper on "The Choice of Treatment for Fibro-myoma of the Uterus," an abstract of which will be found on page 291.

In the discussion that followed,

DR. J. A. MANSELL MOULLIN remarked that the paper to which they had just listened would have been a very interesting one had it been before them ten or fifteen years ago, and that considering the brilliant results obtained from operative treatment, in his opinion the discussion must centre around Group 1, as all the other groups undoubtedly demanded operation. Dr. Inglis Parsons had told them plainly that no operation was permissible in the first group, and that he would give medicine. In other words he would wait until the tumour had produced symptoms before operating. He (Dr. Mansell Moullin) held that if a

tumour of any size was growing in a woman of, say, 40 years of age, the sooner it was removed the better. With regard to large tumours in the abdomen he did not think there was any considerable risk in removing them; there was much more risk of degenerative changes taking place in the tumour if left behind. As to removing the appendages, that operation, he thought, was one of considerable danger and was often not feasible when the abdomen was opened. Under any circumstances the operation was just as dangerous as hysterectomy, and consequently it was better to remove the tumour at once. The question of the removal of the ovaries at the same time as the removal of the tumour and the body of the uterus was one open to discussion. He had no evidence of the value of leaving the ovaries behind in women of 40 or 45 years of age. He usually left one ovary, if possible, in women of about 30 to 35. Dr. Parsons had considerably enlarged upon the dangers attending operation. He was diametrically opposed to everything Dr. Parsons had said.

Mrs. SCHARLIEB said she completely agreed with what Dr. Mansell Moullin had said as to the lines on which to deal with these tumours. No one could foretell what was going to happen to a fibroid. It had been her ill fortune in several cases to leave one alone and to find subsequently that some accident had overtaken it, so that she was obliged to do an operation under much more disadvantageous circumstances, or the patient had died before such an operation.

Dr. MACNAUGHTON-JONES said that the whole discussion appeared to resolve itself into the comparative value of treatment of uterine myoma by electricity and Apostoli's method. In the early days of that treatment he had tried it and abandoned it, having had one fatal result. This occurred in a patient who suffered from catalepsy and most severe metrorrhagia, and in whom the uterine wall was excessively thin. This was the last case in which he had tried it. In considering the treatment of any form of myoma by this method, it had to be remembered that it had been tried most extensively by many of the most distinguished gynaecologists abroad, and had been almost universally abandoned. Such authorities as Martin and Mackenrodt had given it extensive trial and had rejected it. Had Dr. Inglis Parsons had no unfavourable results? In those cases in which symptoms had been temporarily relieved, were there subsequent degenerative changes in the myoma, and had he used it in cases in which degenerations were present? It was not possible to differentiate the various forms of myoma in regard to the treatment applicable to certain groups, and systematically to dogmatise on any particular special form of treatment for each. Complications, adnexal and other, made it essential to deal with each case according to its special features.

Dr. MACPHERSON LAWRIE protested against the sweeping disapproval of electricity in those cases. He could emphatically say that electrical treatment alone without any other application had in a good many cases in his own experience been of service, diminishing the hæmorrhage, removing the pain, and in some cases leading to considerable shrinking of the tumour. There was little danger in hysterectomy as the operation was now performed. But putting the risk altogether on one side, surely it was a serious thing to remove the uterus from any woman. It was not to be done merely because they found a tumour.

Dr. R. BELL thought the paper they had just listened to was one of very great value, because Dr. Inglis Parsons understood the therapeutics of electricity perhaps as well as any medical man in the profession, and was also an expert and fearless surgeon. He was not afraid to operate, but he conscientiously believed that electricity was more beneficial and conservative than the wholesale removal of uteri for tumours. He himself did not altogether agree with Dr. Inglis Parsons in his estimate of electricity. He had tried it, and perhaps the reason he had failed was because he did not understand its application so thoroughly as Dr. Inglis Parsons did. He (Dr. Bell) did not believe, though

a great many people supposed it did, that electricity acted by electrolysis. In the paper which he read before the Society in April, 1896, the plan of treatment for fibroids he advocated consisted in the administration of mammary gland. He had applied that treatment persistently with excellent results. He himself had also seen numbers of cases get quite well with that method of treatment supplemented with chloride of calcium. He happened to have a case just now which has been under his treatment for three months. The patient came to him, and on examination he found a fibroid in the anterior wall of the uterus. The patient was æt. 50, and although the menorrhagia had not ceased, yet the tumour was reduced to half its previous size.

Dr. EDGE said when he was a resident in a gynaecological hospital he used to see a great deal of Apostoli's treatment, but he never formed a favourable opinion of it. As to curetting he must say that he had entirely given it up. With regard to myomectomy he was strongly in favour of it in cases where they could be sure of removing all the growths. In reference to removing the ovaries his experience had inclined him to remove both ovaries and tubes with the uterus, except in young women. But even in these latter cases he did so very unwillingly because he had had several cases where an ovarian cyst had formed or a tube become occluded or distended, and he had had to reopen the abdomen.

Dr. R. T. SMITH said he would never think of removing the appendages because of a myomatous tumour. With regard to the use of electricity, personally he had discontinued it for fifteen years. He came to the conclusion with regard to electricity that if it did any good it practically did that good most of all by enlarging the canal of the uterus to some extent, in that way greatly relieving cases of dysmenorrhœa. Dr. Parsons said he had not known any bad effects from the use of electricity. He (Dr. Smith) remembered one case being shown where electricity had been used for the large tumour with the result that sloughing took place and the patient narrowly escaped with her life. He had known fibroid tumours completely disappear with pregnancy. He very much doubted that in any given case of fibroid tumour they should operate. They had to consider every case on its own merits. He believed the general principles of medicine as applied to cases of fibroid tumour were of enormous value.

THE PRESIDENT opposed Dr. Parsons' view that the patient ought to be told about the fibroid and the treatment carried out. The knowledge that she had a tumour would dominate her whole life afterwards and she would never be at rest or happy. Therefore his own practice was to tell the friends of the patient about it, and that they should let him see her again and again, and when he saw her he would tell her there was something not quite right but that the medicine might get her quite well again. He thought a patient should always be given medicine as a rule in the first place, and it was only when she came to the gynaecologist that the removal of the tumour was entertained. As to the operation of myomectomy, he read a paper before the Society a good many years ago and told of one case in which he found twenty-five fibroids, which he removed, and the patient did very well. If there was a single tumour he removed it by myomectomy, if a number of small tumours he performed hysterectomy. The removal of the appendages was an operation which he used to do many years ago, but he thought the results were not very trustworthy. When they removed the uterus it was certain that they removed the disease and there would be no more trouble, whereas if they removed the ovaries the trouble might not disappear, and in a certain number of cases it did not disappear. As to the patients who Dr. Parsons said had got on very well with the electrical treatment he would like to know what kind of a life they led. He (the President) had a patient at the present time who had been an invalid for fifteen years, only occasionally going about, taking a drive and the like. She nearly died with obstruction

of the bowels. That patient's life was really not worth living. That was his experience in cases which had got large fibroids. In the great majority of cases he thought hysterectomy was the best operation to adopt.

Dr. INGLIS PARSONS, in reply to the various criticisms, first referred to the case just cited by the President and maintained that if she were treated by electricity she would not be a chronic invalid. They could not get a patient and her pelvic organs restored to health by operating, but they could do so by the use of electricity. As to the medicines he had mentioned, he had done so because general practitioners brought the cases without having tried the medicines. The specialist ought not to try those things that ought to be done by men in general practice. He quite agreed with what the President had said as to the removal of appendages. In reference to other criticisms Dr. Parsons said it was absurd to class large fibroids with small ones for operation, where the patient suffered from nothing but the menorrhagia. It was very rare for a case with fibroma to die if left alone. He was not bringing forward electricity for all kinds of tumours, but if the treatment by electricity was not successful, there was no difficulty in removing the uterus afterwards. It was not his experience that the use of electricity made operation more difficult. He had been using mammary gland extract for the last eighteen months, but he had not used it sufficiently to come to a conclusion on the subject. He could say that in those cases where he had tried the treatment it had certainly had a beneficial effect. As to curetting, he only recommended it as a palliative in certain cases where the patient refuses any other operation.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF MEDICINE.

MEETING HELD FRIDAY, MARCH 3RD, 1905.

SIR J. W. MOORE, M.D., in the Chair.

EXHIBITS.

Dr. W. J. THOMPSON—A Case of Alopecia affecting the entire scalp of a boy.

A CASE OF HYSTERICAL CHOREA.

Dr. JAMES CRAIG exhibited a case of hysterical chorea in a girl, *æt.* 22. There is no neuropathic family history obtainable. She was in good health, and was occupied as a laundress until two years ago, when she found herself unable to write on account of a shaking in her right hand. The shaking then extended to her head. At the present time she has a rhythmical rotary tremor of the head—coarse in character, particularly when she is under observation, but at times much finer, and frequently not to be noticed at all. There are no contractions seen in the facial muscles. There is a fine tremor occasionally present in the hands, but arhythmic contractions, inco-ordination or weakness of muscles are not observed. There is an absence of any of the other manifestations of hysteria, nor is there any evidence of any organic disease of the nervous system. Rhythmic hysterical spasm is the better name for the condition, as the term chorea is misleading.

Dr. BEWLEY said that the case reminded him of other diseases. As to what was the pathological and anatomical basis underlying tremors we knew very little. Various conditions affecting the nerve-cells resulted in the production of these movements. For example, they might be present in old age, or in diseases such as paralysis agitans, but what really caused them we did not know. As regarded prognosis he thought the patient's chances of recovery were poor.

SEQUEL TO A CASE OF INNOMINATE ANEURYSM REPORTED IN 1898.

Dr. CRAIG contributed a short paper on the further history of a case of innominate aneurysm, reported by him in 1898. The patient had recovered from the aneurysm of the innominate, but seven years from its onset he had died suddenly at Wiesbaden from the rupture of an aneurysm of the aorta, which was the size of the head of a new-born child, and had terminated life by rupturing into the œsophagus. He detailed the result of the *post-mortem* examination made by Drs.

Stein and Altdorfer, of Wiesbaden, who had kindly forwarded him the report.

Dr. MARSON said the perforation into the œsophagus was interesting, and out of sixty-eight cases reported by one observer only one had terminated in that way. He had had a case in which perforation had occurred into the œsophagus, but in that case there were all the usual symptoms, and there was something to go on in making a diagnosis. What was the cause of the aneurysm in Dr. Craig's case, as his patient seemed to have a healthy liver and to have none of the usual specific causes?

Dr. T. G. MOORHEAD said the case was very interesting, from the fact that it pointed out that aneurysm, except in cases where there was trauma or some obvious cause, was a constitutional and not a local disease. The case also illustrated the fact that aneurysm had a tendency to recur, and what he might call the constitutional diathesis to aneurysmal dilatation.

Dr. W. J. THOMPSON said that about six years ago he showed a specimen before the Pathological Section of a case of a labouring man in middle life. He was very steady, and had never complained of pain or any trouble. While attending to his business he suddenly fell down and blood came from his mouth. On examination life was found to be extinct. The *post-mortem* showed the presence of an aneurysm, the size of a walnut, situated in the aorta about two inches above the cardiac end of the stomach. It had perforated into the œsophagus. There was no atheroma or disease of the heart.

Dr. CRAIG said that, with regard to the cause of the aneurysm, the patient was gouty, and attributed the start of the aneurysm to a strain received in lifting a press. The chief point of interest was that this enormous aneurysm could be lying in the thorax, and the patient be apparently perfectly well.

THREE CASES OF PNEUMONIA IN PREGNANCY.

Dr. DRURY read a paper on pneumonia in pregnancy, illustrated by three cases which he had met with. This paper will be found in another column, under the heading of "Original Communications."

Dr. NINIAN FALKINER said he considered the subject a most important one, and congratulated Dr. Drury on his successful treatment, and gave some statistics of the mortality in cases of his own. In England in 1901 the cases of death from pneumonia in pregnancy or childbearing showed a percentage of 3.42 of all the deaths of women associated with these conditions. In 1902 the percentage was 6.46; and in Ireland in 1902 it was 1.52 per cent. of all deaths definitely returned as either caused by or associated with pregnancy or childbearing.

Dr. DAY said that, with reference to the question of pneumonia in pregnancy, his experience was that women who were young did not die. He had never had to use forceps in a case with fever. The child's chances of survival were very slight. Cases of abortion gave more trouble, or cases in which the foetus was not viable. Another curious error was that pregnant women did not get enteric fever; this was very erroneous. He doubted whether a woman who was pregnant was less liable to get pneumonia than non-pregnant women. There was no reason why such patients should get cyanosis as long as one lung was free. What you had to treat was the fever and want of sleep; in other words, the nervous disturbance. There was also a certain amount of hypertrophy of the heart, and it was the heart which usually failed. In these cases no internal examination should be done, and the case not interfered with. One thing which made pneumonia peculiarly liable to cause abortion was the high temperature. He had seen small-pox also occurring with pregnancy, and it did not seem to interfere with the ordinary course of the disease. The same thing applied to measles and enteric fever. He thought it was important to have got these three cases together as emphasising the point that pneumonia was not such a dangerous complication as was usually supposed.

Dr. NEN said that delivery in these cases was usually very easy owing to the prematurity of the foetus. He had seen also several cases in the last stages of phthisis

in which the delivery was perfectly easy. He had seen a case of placenta prævia occurring in a patient who had advanced phthisis. She got over it well, and had a normal child afterwards.

Dr. MOORHEAD said he had had one case of pneumonia in pregnancy. The patient was a primipara, æt. 37, and about four and a half or five months pregnant. The whole of the right lung was involved. Convalescence was prolonged, and there was cyanosis from an early period and all through the fever. A perfectly healthy child was born at full term.

Dr. DRURY thought that gynaecologists should pay more attention to the statistics of these cases. The tendency to abortion was not so great when the fever occurred at an early term; but in most cases, especially in the later periods, the fœtus was usually not retained.

WEST-LONDON MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD FRIDAY, MARCH 3RD, 1905.

C. M. TUKE, Esq., President, in the Chair.

Dr. ALEXANDER MORISON read a paper "On Boldness in Treatment of Certain Phases of Pneumonia." The principal points referred to by Dr. Morison were (1) the treatment of high temperature by the application of ice to the body or to the head alone; (2) the conservation and relief of the heart by frequent injections hypodermically of strychnine, and the administration of turpentine internally, and (3) the relief of the heart by blood-letting.

Dr. G. A. SUTHERLAND, in referring to the use of strychnine, said that as a rule insufficient doses were given, and advised the drug to be used at frequent intervals, and in large doses until the physiological effects were produced.

Dr. A. ELLIOT did not think energetic and bold measures for reduction of temperature should be used unless the temperature exceeded 104° or 105°, and then he found that application of ice to the chest was as a rule badly borne, and he recommended cold sponging as preferable. Referring to blood-letting, Dr. Elliot considered that the amount of blood withdrawn was not of such great importance as the rapidity with which the loss of blood was effected.

Dr. MORISON, in reply, agreed with Dr. Elliot that it was not so much the quantity of blood withdrawn as the rapidity with which it escaped which relieved the surcharged heart.

Mr. CECIL LEAF read a paper on the "Clinical Causes of Cancer of the Breast," in which he proved by a very complete table of statistics that not only one but many clinical causes of cancer exist. The special points discussed by Mr. Leaf were (1) age, (2) state—married or single, (3) family history, (4) lactation, (5) previous diseases of breast, (6) injuries, (7) corsets, (8) worry and anxiety, (9) residence, (10) diet—consumption of meat, salt, uncooked vegetables, &c., alcohol, and (11) miscellaneous. General health, occupation, and infection.

Dr. S. D. CLIPPINGDALE considered that the coincidence of cancer with consumption to be of great clinical importance, and he also drew attention to a paper published by himself in which he endeavoured to show that both these diseases in London were more common in the low-lying districts near the river, irrespective of soil.

Mr. J. G. PARDOE wished to impress upon the members the importance of the infectivity of cancer, and gave a practical illustration of the same.

Mr. F. LAWRENCE considered cancer to be, without doubt, hereditary, and also possibly infectious.

Mr. LEAF made a few remarks in reply to the speakers.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING HELD AT LIVERPOOL, MARCH 17TH.

Dr. LLOYD ROBERTS in the Chair

Dr. A. J. WALLACE showed a new instrument described as an "elevating vaginal director" designed to facilitate the working of a drainage incision into the

vagina from the abdomen. This was an improvement upon the operator's own finger, as it could be introduced and held in the vagina by an assistant who could push the posterior fornix up to the abdominal incision.

Dr. WALLACE also gave the clinical features of a case of Inoperable Cancer of the Uterus, with symptoms of bulbar paralysis; and Dr. W. B. WARRINGTON described the *post-mortem* findings and showed sections of the affected portions of the nervous system. He mentioned that secondary carcinoma in the brain was very rare, and that none was found in this case. Thrombosis of the cavernous sinus completely accounted for the paralysis of the third nerve; but there was no gross or microscopic lesion which explained the bulbar symptoms. These, he thought, must be attributed to the state of toxæmia produced by advanced malignant disease.

Dr. LLOYD ROBERTS showed a fibro-myoma of the ovary, the parenchyma of the organ being stretched over one portion of the tumour whose other and larger portion had a peritoneal covering derived from the broad ligament.

Dr. A. W. W. LEA read a paper on TUBERCULOUS DISEASE OF THE FALLOPIAN TUBES, and gave an analysis of eight cases treated by removal of the affected organs. He described caseous, fibrous and purulent types, and regarded the condition as more common than is generally supposed. The removal of the tubes usually permitted of a good prognosis; it was not necessary to remove the ovaries unless these were actually diseased, nor was it necessary to remove the uterus as this could be done subsequently if required. The paper was illustrated by numerous lantern slides.

Dr. S. BUCKLEY emphasised the importance of definite pathological diagnosis, as in some cases presenting the clinical features of tuberculosis, the diagnosis could not be confirmed by the microscope or by cultures.

Dr. W. G. FITZGERALD preferred operating by the vaginal route and removing the uterus together with the diseased appendages.

Dr. H. BRIGGS agreed that the condition is more common than is usually supposed.

Dr. H. ARMSTRONG confirmed the view that there is but slight risk in leaving the ovaries. In the records of twenty years of autopsies at a children's hospital, he had found no case of primary and only one of secondary ovarian tuberculosis. In the tubes the condition was common, but was nearly always secondary.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, March 19th, 1905.

At the meeting of Charité Physicians, Hr. Sonnenburg related his experiences with regard to ANÆSTHESIA BY INJECTION OF STOVAIN INTO THE SPINAL COLUMN.

Experiments on animals had shown that stovain was less poisonous than other material. He had used it in about sixty cases, in which the action was very prompt. He had performed operations on the extremities with it, both internal and external genitalia, several herniotomies, some cases of appendicitis, one gastro-enterostomy, and one case of multiple abdominal abscess. The method failed in eleven cases, probably in consequence of failure in the technique. Anæsthesia of the lower extremities was brought about most easily; from here it mounted to the costal arch, and occasionally as high as the head. He had seen meningitis follow one case. It came on on the tenth day after the operation.

Stovain was procurable in a 10 per cent. solution, sterilised, in glass tubes. The quantity employed was from 0.05 to 0.07 grm. The anæsthesia came on very quickly and lasted about 1½ hours. The after-effects were very slight; at most some backache, some dragging in the legs, and thirst. If drink were given under the hour after its use vomiting might take place once.

The injection was made through an intervertebral space, the patient lying on the side with the

spine flexed; a small quantity of cerebro-spinal fluid was drawn off, with which the solution to be injected was mixed. If blood came away it was a sign that the plexus had been punctured, and another spot should be tried. In old people the injection was more difficult as the space between the vertebræ did not open out so much.

Soon after the injection, paralysis of the legs came on with loss of patellar reflex. The hæmorrhage at the subsequent operation was not great, showing that the vaso-motor nerves were not affected. The anæsthesia of the lower parts of the abdomen and of the intestines was remarkable, indicating that they did not get their sensory fibres from the phrenic and vagus as was assumed, but from the border fibres of the sympathetic.

Hr. Sonnenburg reported

THREE CASES OF INJURY TO THE HEAD.

The three cases immediately followed one another. The first was an epidural hæmatoma, the second a subdural one, and the third a crushing of the brain. The second and most interesting case was that of a woman in middle life who was found unconscious at the foot of some stairs, and in which there was some doubt as to whether the hæmorrhage was traumatic or from apoplexy, and therefore whether an operation should be performed or not. She had Jacksonian epilepsy, but without any symptom of brain pressure. She died without being trephined. The section showed a rather extensive hæmorrhage, probably from the fall.

Exc. v. Bergmann observed that the unilateral epilepsy would have justified an operation, but it was not certain whether it would have done any good or not.

At the Laryngological Society, Hr. Gluck, among other cases, showed a child with a

PULMONARY FISTULA.

through which respiration took place. Two ribs had been resected for empyema, and the costal pleura had been united to the visceral pleura by suture. After some days, when the parts had united, some gangrenous portions of lung were excised. When the mouth and nose were closed the lungs could be filled with air. In cases of inoperable stenosis of the trachea, Hr. Gluck proposed that in place of performing tracheotomy low down and subsequent introduction of a long flexible cannula, a pulmonary fistula should be formed by means of which the ordinary air passages would no longer be required.

At the Society for Psychiatry and Nerve Disease, Hr. Vorkastner showed a

BRAIN PREPARATION.

The preparation was from a single woman, æt. 26, who, at Easter, 1903, awoke with the face drawn sharply to the left. The case was taken to be a rheumatic facial paralysis, and treated by electricity. A year later giddiness came on, pains in the head, and vomiting; there was also some difficulty in swallowing, and the gait was staggering. In June, 1904, she was admitted into the Charité. There were then slight weakness of the right abducens, with greater weakness of the left. There was nystagmus when looking sideways; the corneal reflex was lost. There was right-sided facial paralysis with marked change in electrical excitability. Hearing power slightly lowered. The tongue diverged to the right, and the head was very tender when tapped. There was no motor disturbance in the extremities. A diagnosis was made of an intrapontine new growth. The headache and vomiting continued. Potassium iodide was given but without improvement. Lumbar puncture revealed nothing. Babinski's symptom developed distinctly on the left. The facial symptoms remained unchanged. There was slight sensory disturbance of the left trigeminus. The appearances of the fundus oculi were normal. Death took place suddenly from paralysis of respiration. The pons appeared to bulge a good deal outwards and especially towards the right, and this agreed with the clinical symptoms. The case was probably one of gliosarcoma.

BIRNYRAL.

The *Deutsch. med. Zeit.*, March 9th, has a note on "Birnyral in Hysteria," by Dr. G. Schöffler, of Cannstadt. He says that although not a panacea, in his practice it has proved the best, quickest, and most efficient palliative remedy he has yet met with, and especially in cases in which a rapid action was desired. No disagreeable by-effects were observed, and he is of opinion that from the action of the drug, no such effects may be expected.

The medicine was given in the form of perfumed gelatine perles, containing the birnyral, which is a valerianic acid extract of oil of valerian. In this form it was readily taken by all his patients. He reported five cases in which it proved useful, and he claims that they show the prompt effect of the drug and he prophesies that it is destined to maintain a permanent place in our medical armamentarium.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, March 19th, 1905.

BACTERIOLOGICAL EXAMINATIONS IN INFLUENZA.

AT the Gesellschaft, Kretz gave a *resumo* of his bacteriological examinations in the Franz Josef Spital Institute.

From November 1st, 1904, till January 31st, 1905, he examined twenty-seven cases of influenza, and in every one found the influenza bacillus in varying quantities, but he confessed that sixteen of the cases had very few to record of the inter-current type, while eleven others had very large quantities. He affirmed that the catarrhal form of respiration was more frequent this year than in any preceding. Clinically, it resembles the "grippe," as he had forty-three cases placed before him as such, but no influenza bacilli were present. It is equally as infectious as influenza and has often clinically been mistaken for it.

He is inclined to believe that the endemic "grippe" is the parent of the pandemic influenza, though they are supposed to be different.

Sternberg said that his own experience coincided with that of Kretz. In seventy cases of supposed influenza, only thirteen, or 18.5 per cent., had influenza bacilli. As prosector of the Franz Josef Spital he has met with five cases only where the bacteriological examination was positive. During the same period last year the positive cases of the bacilli in the lung were 7 per cent. This is a higher number than in 1899, but nothing to that met with in the winter of 1900, when the positive cases met with rose to 100, which may be cited as an epidemic year of influenza.

DYSENTERY ANTITOXIN.

Kraus reported that he along with Doerr in 1903 elaborated a normal antitoxin for dysentery from the serum of a goat. It was also found to produce immunity if the injections were repeated until they became reactionless, or as long as the avidity existed. Since that time these two authors have been plodding away on the subject, and now affirm that a curative antitoxin can be obtained from the horse which in time loses its effect and has to be repeated. One of their examples was a demonstration of the serum in vitro on the specific poison, which it neutralised. They have further discovered that the quantity and not the quality of the antitoxin is the most effectual. They gave it as a rule that a certain avidity existed between the antitoxin and the poison. In the discussion that followed Basch expressed surprise at the extraordinary changes that take place in our art during a lifetime. In 1868 on his return from Puebla, where he had been during several epidemics of dysentery, he expressed a strong belief in the bacterial infection of the disease, and at that time brought forward testimony convincing to himself but scoffed at by Virchow and others. Notwithstanding this scanty sympathy, he left Europe with a firm conviction of applying anti-bacterial remedies such as creosote in the treatment of the disease. He persevered with these drugs with apparent success, and

from time to time reported progress, till Virchow more seriously examined the stools and affirmed that the etiology of the disease was bacterial. There are still some who doubt this origin, but he felt sure they were decreasing every year.

CHOLELITHIASIS.

Fink next gave the Society a long description of the treatment of cholelithiasis under the balneological method, which he supported by reference to many of his former publications.

Clairmont remarked that the chronic inflammation of the gall-bladder did not always result in malignancy, as Riehl had affirmed. In Eisberg's clinic he had a record of fifty-six cases of cholelithiasis, 19 of whom he treated in hospital without operation, 24 were operated upon and the other 13 were treated with Carlsbad water, under which they improved. From the 24 operations, 18 had cholecystectomy performed and 6 cholecystostomy. The third group comprised 13 cases of carcinomatous gall-duct, which is certainly a very high number. In recommending the form of operation he thought the ideal method was cholecystectomy. Calculi were not always to blame for the malignant origin, as 6 of the operations were for closure of the choledochus where no stone or history of stone could be found, although severe icterus was present.

Schnitzler thought that the radical treatment advocated by Fink could not be obtained by the use of Carlsbad water. He was in favour of early operation, if any good had to be done.

Eisberg criticised the *technique* of the operation, and thought that cholecystectomy might be well enough in animal experiments, but in practice there was danger. When the cystic duct was tied close up to the choledochus the danger was not so great, but he had often found troublesome bladders forming. Cholecystostomy should never be practised in cholelithiasis. He had himself operated seven times in such cases, twice on account of cholelithiasis; twice for cicatricial stenosis of the ductus choledochus, and three times on a reputed inoperable case, all of whom did well. Fink, in concluding the subject, thought that many of them had over-estimated the carcinoma occurring as a coincidence in cholelithiasis. Czerny had treated 116 cases and only met with 30 carcinomatous, which he thought was a reasonable percentage, agreeing with that occurring in other parts of the body.

Operating Theatres.

GUY'S HOSPITAL.

HYDRONEPHROSIS DUE TO MOVABLE KIDNEY.—Mr. CLEMENT LUCAS operated on a woman, *æt.* 31, who had been admitted for pain and a lump in the right side. She had first noticed the symptoms about ten or eleven months ago. They, however, soon disappeared, but returned six months before admission, and since then had been fairly constant, culminating a few days before, when the patient, in addition, was sick. She stated that on some occasions the lump was more noticeable than at others. On examination the right kidney could be felt coming down at each inspiration, and the organ was larger and harder than normal. When the patient was examined in the kneeling position, a distinct hollow was evident in the right loin immediately below the last rib, caused by the dropping away of the kidney; the organ fell as low as the umbilicus, and the hand could be pressed in through the wall of the abdomen below the ribs above its upper end, and when the patient was on her back the tumour could be slipped back under the ribs so as no longer to be felt. A.C.E. having been administered, an incision four inches long was made, about an inch and a half below the last rib. The

muscles were divided until the lumbar aponeurosis appeared; this was opened and the quadratus lumborum exposed at the back of the wound. Some very strong fascia was next divided and the perinephritic fat came into view. The kidney was movable in the wound, and the upper end of the viscus was found where the lower end normally should have been. On exploring the organ more fully it was discovered that the renal structure was largely destroyed as the result of hydronephrosis. The dilated pelvis formed a bag distended with fluid protruding into the wound. All the fat between the kidney and the muscles was torn away, and two inches of the last dorsal nerve were removed. When the kidney was now raised into its normal position, the pelvis emptied itself of the accumulated fluid, showing, as Mr. Lucas pointed out, that the dropping of the kidney was the cause of the hydronephrosis. The finger could be invaginated in all directions into the kidney, indicating, Mr. Lucas remarked, how much wasting of the secreting structure had taken place as a result of the fluid pressure. The lower end of the kidney was then sewn to the muscles by six fine silk sutures, some passing through the upper edge of the cut muscles, others through the quadratus lumborum. The divided muscles were next sewn up with interrupted silk sutures, and finally the skin with salmon gut and horse-hair, a small gauze drain being left in the posterior end of the wound.

EARLY TUBERCULOUS NEPHRITIS WITH STRONG FIBROUS ADHESIONS.—The same surgeon operated on a girl, *æt.* 19, who had been admitted for pain in the left loin. There was a history of tuberculosis in her maternal aunt and in her grandmother, but her parents and her brothers and sisters were healthy. The patient stated that when a small child she had suffered from "consumption" of the bowels. For two years she had had a continuous aching pain in her left side, which had been getting worse; this was accompanied by distension of the same side, and she said that when she turned over in bed she felt something moving. The urine came away freely, but micturition caused a burning pain; there was no blood in the water, but it was thick at times, and there was tenesmus occasionally. The pain was increased by exertion. When Mr. Lucas saw her he used his "flexion and stamping" test for renal calculus; this caused pain during flexion but no hæmaturia or colic followed, therefore it was negative. A.C.E. was given and an incision about four inches long made immediately below the last rib in an oblique direction. The muscles and the lumbar aponeurosis were divided when the perinephritic fat was discovered in large quantities. The kidney was small and high up under the ribs. On pulling it down and examining it, a very strong fibrous adhesion was found attached to the lower border of the organ, a distinct dimple being felt in the lower end opposite the attachment of the adhesion. The pelvis of the kidney was carefully examined, but no evidence of stone was obtained. Mr. Lucas said he came to the conclusion that the dimple opposite the adhesion indicated a localised nephritis of tuberculous origin. Had there been any distension of the kidney with pus, or had the disease been extensive, he would have considered the question of removal or of temporary drainage previous to removal, but as the disease was localised and slight, he thought that the disturbance

in the circulation of the kidney brought about by the examination might effect a cure. In cutting down, the last dorsal nerve was exposed, and two inches of it were excised. The muscles and skin were sewn up. No drain was employed. Mr. Lucas explained that his "flexion and stamping" test for renal calculus consisted in flexing the knee strongly on the abdomen (whilst the patient is standing on the opposite leg and supporting himself against any convenient object with the opposite hand and arm), and then suddenly letting the heel down on the ground. In the case of a movable stone in the kidney either an attack of colic or of hæmaturia may be caused this way. He stated that this test was first published by him two years ago in the *Lancet* as a lecture before the Hunterian Society on the "Symptoms and Diagnosis of Stone in the Kidney," and that some examples in which the test was used were embodied in a paper on some cases in which the X-rays had failed to demonstrate a stone in the kidney, published in the *British Medical Journal*, October 1st, 1904. Mr. Lucas pointed out that with regard to the present case, the adhesion to the kidney found at the operation accounted for the pain caused in extreme flexion of the thigh on the abdomen.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, MARCH 22, 1905.

NATIONAL LEAGUE OF PHYSICAL EDUCATION.

In these days when societies, associations, and leagues to accomplish every desirable project and to circumvent every undesirable one abound in every corner of the land, it cannot be without diffidence that one ventures to bring forward the claims of yet another. But the body of which we would speak—the National League of Physical Education and Improvement—is so wholly admirable in its aims, and is being fathered under such favourable auspices, that we feel that there ought to be room for it, even in the crowded state of the philanthropical arena. The most important consideration that should weigh with the promoters of any such scheme is, it appears to us, whether the work that it lays out for itself can best be done by inaugurating an entirely new organisation, or whether that work cannot be as well, or even better, done by the co-ordination of existing agencies. This is a matter that should

be most carefully inquired into and thought over, not only because of the risk of possible failure, but also in the interests of economy. Subject to this proviso, not only can no fault be found with the objects of the National League of Physical Education and Improvement, but rather the warmest sympathy extended to them. It will be within the knowledge of most men that keen interest and great activity have been displayed by Sir Lauder Brunton in this question of improving the physical education of the people of this country, and many will doubtless have read his speeches on the subject. The concrete result at which he aims is the establishment of a league for the purpose of improving the national physique—a league that shall be national in every sense of the word. He wishes that it may be so constituted that every corner of the United Kingdom may be permeated, so that every man, woman, and child may be influenced and affected by it. Such a proposal is—to use a vulgarism—rather a "tall order," and if it is to succeed the ground must be carefully prepared and general interest attracted to it. It is likely enough at the present moment that a good body of adherents—central and local—may be gained, for the physical deterioration scare has not entirely passed away. But it is well to bear in mind the shortness of the public memory. During the last few years a dozen matters that excited universal excitement at the time they occurred have fizzled out, almost before the full facts about them were brought to light. The unpreparedness of our army at the time of the South African War is now discarded as an electioneering cry, and, to take a recent instance, the North Sea incident had not time to become even an *affaire* before it was replaced in the popular mind by other and more parochial matters. To recall the latest example of medical activity in influencing public opinion by propagandist associations, we have only to mention the National Association for the Prevention of Tuberculosis, which started some five or six years ago with a fanfare of trumpets in universal acclamation, and is now struggling to keep itself in being. It behoves, then, the founders of the new League to take counsel with all the admirable agencies already at work, in order that the multiplicity of advisory cooks may not spoil the hygienic broth—a result that would be as far from the promoters' wish as are the physical conditions they propose to combat. Speaking at the Manchester Children's Hospital, Pendlebury, on February 26th, Sir Lauder Brunton touched on the points towards which the League's energy would be turned, and though none of them are new, they are all of vital moment. The education of mothers in the management of their own health and that of their children, the problem of the milk-supply, physical exercises for school-children, "under-feeding," open-air recreation, swimming, over-crowding, and last but not least, alcoholism—these are some of the chief questions with which the League proposes to grapple. A programme so

ambitious would seem to require the enthusiasm of the most incurable optimist to see it carried further than the stage of leaflets and lectures, but we hope that a few such incurable optimists will be forthcoming, and that they will not find themselves overburdened with the weight of the load to which they put their shoulders. Success can only be attained, in even a modified degree, by linking up every available social and philanthropic force in the community, and prominent among these must come the element of personal interest in the cause. In several towns there exist already "health societies" in which enlightened medical men and philanthropic ladies work together for the hygienic betterment of the poor, and it will be by enlisting a corps of workers who will give their services freely to visit, talk to, and influence the rich and the poor, and to keep such influence alive when once created, that alone the object of the League can be accomplished. But to arouse and maintain such an amount of interest in people is a task sufficient to make the stoutest heart quail.

PUERPERAL FEVER.

WHETHER the subject be regarded from the point of view of its intrinsic importance to the public, or with legitimate pride by the profession on its gradual disappearance from the mortality statistics of the lying-in hospitals, puerperal fever well deserves the dedication of the special current number of our contemporary, the *Practitioner*. From the personal aspect there is no disease which brings such devastation into happy family life; it seizes the young mother at the moment of her greatest pride and joy, it leaves the infant helpless when most it needs constant care, and it leaves the father embittered and lonely when he should be entering on the pleasures of domestic life. From the national point of view its ravages are of equal importance, for it takes away the very class who are of most service to the healthy life of a community—the child-bearing young women. The great Napoleon once remarked that the woman to whom the State owed most was she who had borne most children; if this be so, then anything that interferes with physiological child-bearing is that which, on public grounds, demands the first duty of the physician. And, unfortunately, although as a factor of mortality in the lying-in hospitals throughout the country puerperal fever is now almost negligible, it figures as largely as ever in the death returns of the country as a whole. Looking at the death statistics for England and Wales from 1847 up to 1900, as quoted by Dr. Williams in his *Milroy Lectures* last year, we find that whereas in 1848 1,365 women died from septic conditions in the puerperium, in 1900 the number was 2,079. It is indeed a sad reflection that the improvement in hospital returns has had no parallel in the results of private practice. During the years 1902 and 1903, the septic mortality in the Rotunda Hospital was only 0·1 per cent., with a total of 7,603 patients attended; in Ireland,

as a whole, the mortality in the same two years was 0·216 and 0·231 per cent. respectively. The reason of this marked difference is not far to seek. In the hospitals aseptic precautions are rigidly enforced. In private life it is always difficult to ensure complete sepsis, even when the greatest care is taken; in the great majority of cases, however, where the confinement has been attended by a midwife, septic precautions have been ignored or, what is just as bad, ignorantly and carelessly used. It seems to us nowadays almost incredible that at any time the infective nature of puerperal fever was unrecognised, since by any careful observer it may be seen to track the footsteps of particular accoucheurs or midwives. Yet Gordon, of Aberdeen, was regarded as mad when he wrote in 1795 that he could venture to foretell what women would be affected with the disease upon hearing by what midwife they were delivered. In one epidemic recently investigated by Dr. Williams in Glamorganshire, all the fatal cases had been attended by one midwife. This reminds one of the famous Dr. Rutter, of Philadelphia, who, in 1842, infected in the course of a twelve-month some seventy patients from an ozæna of his own person, and yet "could not readily believe in the transmission of the disease in the person of a physician." There seems no doubt that could midwives be properly trained the present deplorable mortality would greatly diminish. But this is no easy matter to accomplish. It is very well to forbid untrained women to practise as midwives, as has been done by the recent Midwives Act, but when they retire in large numbers, as they are doing throughout the country, who is to take their place? In Northamptonshire, Dr. Paget, the Medical Officer of Health, calculates that 60 per cent. of the midwives at present practising will retire rather than put themselves under the Act. There is great danger that in cases like this the poor will, for some time at least, be left without any help. In time, however, the supply is bound to right itself, and with a corps of trained midwife-nurses throughout the country, women who know how to keep themselves clean, and when to send for medical help—no easy matters—we may come to look for the gradual disappearance of a disease which more than any other is a reproach to our humanity and civilisation.

MEDICAL MEN AND SCANDALOUS ACCUSATIONS.

THE recent trial of the divorce case *Miller v. Miller and Fowler* throws up into strong relief the danger that medical men run every day from having as patients people who may be, and often are, unscrupulous adventurers. Unlike a lawyer, a doctor cannot pick and choose his clients, but like the rain must minister to the just and unjust alike. The peculiarly intimate relations that must necessarily exist between doctor and patient, too, place the practitioner in an unenviable position if adventurers try to make him a catspaw to accomplish

nefarious designs. The case under notice differs but little from half a dozen similar cases that have occurred in the last few years, in which a husband has sought a divorce from his wife on account of alleged adultery with the family doctor. Miller, the petitioner in the action, was a bank cashier who lived at Thornton Heath, and he alleged that frequent notes were sent to Dr. Fowler by Mrs. Miller, that on several occasions they had been alone together under what his counsel was pleased to call "circumstances of grave suspicion," and finally that his wife had made a confession to him. Fortunately, the husband himself cut but a poor figure in the box, it being admitted that he had seduced his wife before marriage, and only married her after a child was born. One of the servants who appeared for the petitioner was shown in cross-examination to have been turned out of home by her father, and after an unsatisfactory career to have landed under the auspices of the Salvation Army, whilst the other servant gave evidence of no value. Perhaps the most suspicious element of the whole case, however, was the appearance of the wife to give evidence for her husband, and she, too, was utterly discredited by the jury. Dr. Fowler, happily, was a methodical, businesslike man, and kept a private diary as well as his professional day-book, from which he was able to show his movements on the days on which adultery was alleged; he gave his evidence clearly and positively, and after the judge's summing up, the jury found for him without even leaving the box. Loud applause greeted Sir Gorell Barnes' declaration that he left the court without a stain on his character. So peculiarly vicious are actions of this kind, and so subversive of the public welfare in their relationships with their doctors, that we hope that the Public Prosecutor may see his way to take the matter a step further. In the meantime, we understand that Dr. Fowler is to be entertained at dinner by his colleagues in the neighbourhood to show their sympathy for him in the worry and anxiety to which he has been so ruthlessly subjected, and we cannot leave the subject without mentioning that the whole of the defence and its heavy costs were borne by the London and Counties Medical Protection Society, of which Dr. Fowler was a member. We warmly associate ourselves with all right-thinking people in offering him our warmest congratulations on the result of the action.

Notes on Current Topics.

Bloodless Surgery.

EVERY business man knows the importance of a good "catch-word" in promoting the interests of his specialty; consequently, we see every hoarding and magazine aflame with grotesque philological barbarisms whose object is to fix themselves in the minds of people by their whimsical sound or paradoxical appearance. "Grey" pills would not have half the sale they enjoy

unless they were recommended for "grinning greenhorns," and Albatross's Syrup becomes immediately comforting to the imagination when conjoined with the title of the gentlest of female relatives. So, too, surgery seems to lose half its terrors when described as "bloodless," and since "bloodless surgery" caught on in connection with Lorenz's methods, one was bound to have many followers in the anæmic track of their author. The latest of these admiring disciples is Mr. Frank Matthews, M.R.C.V.S., who probably sees an opening for bone-setting in London now that Mr. Atkinson has passed away. A lecture was given by this equine surgeon on the 9th of this month, under the presidency of a Mrs. Leigh Hunt-Wallace, on the marvellous cures he had wrought by his bloodless surgery, and on how he had been able to bring these wonders about. Venturing to leave the realms of comparative anatomy of which, in view of his veterinary diploma, he may have presumed to have some acquaintance, Mr. Matthews plunged into a disquisition on the peculiarities of the human skeleton, of which it may also be presumed his knowledge was less profound, and thence he led his audience boldly into the domains of human pathology and surgery. Examples of his skill were shown in the persons of a man who had injured his hand at boxing, and after treatment was "able to put his coat on again"; and a patient who had suffered from that rare accident, "slipping of the spine"—also cured. Several children were also brought forward as "living testimony" to his genius for bone-setting, and the whole meeting was gently paragraphed in the Press. We do not know quite what disciplinary powers the Royal College of Veterinary Surgeons are possessed of, but we hope that they may be able to deal with a flagrant case of this kind. Veterinary surgery is a sufficiently exacting science to engage the whole attention of its practitioners, and if any of the latter try to combine with it the functions of a human quack, the sooner their Alma Mater is rid of any participation in their deeds the better would it be for all parties concerned.

Diseases at Panama.

THE greatest difficulty met by De Lesseps, and that which finally led to the abandonment of his undertaking at Panama, was the impossibility of coping with the disease which ravaged the workmen. It is of interest, therefore, to learn what diseases are found most troublesome by the Americans now at work in the same district, and on this subject much information is given by Dr. Sutton, of the United States Navy, in a recent paper. Dysentery, the disease from which the French suffered most, gives but little trouble to the Americans, though natives suffer considerably. The freedom of the "whites" is due to the rigour with which the regulations regarding water filtration are enforced, and the intelligent carrying out of orders by the workmen. Malaria is at present by far the most troublesome disease,

the æstivo-autumnal type being that most commonly found. The adult natives, although showing no symptoms of the disease, are, as a rule, thoroughly infected with the organisms. Dengue is, next to malaria, most troublesome to foreigners, and no treatment has any influence on it. Beri-beri is common, and principally affects the Chinese, who, by the way, have lost no time in getting to Panama. Infection with intestinal parasites is practically universal, nearly every faecal specimen showing eggs of half a dozen different varieties. Of these the most important is *uncinaria*. Sunstroke is common among new arrivals, and causes some deaths. Yellow fever is not endemic, and but rarely occurs.

The Henry Phipps Institute.

A VERY interesting experiment in the treatment and prevention of consumption is being carried on in the States under the above name. The Institute was founded on February 1st, 1903, by Mr. Henry Phipps, for "the study of the cause, treatment and prevention of tuberculosis, and the dissemination of knowledge on the subject," and it started its work, with true American alacrity, the next day. The work is being carried on by clinical and laboratory research, and by public lectures on various points in relation to tuberculosis. The clinical work is conducted in a large dispensary, as well as in the hospital, and, as might be expected, the number of patients much exceeds the capacity to deal with them. At the end of the first year a staff of sixteen medical men was engaged in the Institute. An interesting point is that the nurses are girls who have been themselves cured of tuberculous disease. Among the distinguished men who have given lectures under the auspices of the Institute are Osler, Trudeau, Woodhead, and Marigliano.

The L.S.A.

THE Society of Apothecaries is—rightly, we think—indignant at the action of a solicitor engaged in the West London Police Court in describing the licence of the Society as the "lowest degree a medical man could take," and their clerk has written to the papers to point out the diploma can only be obtained after a broad and careful examination in all three departments of medical practice. Comparisons between medical qualifications are no less odious than comparisons in general, and for that reason we need not attempt a survey of some other qualifications which, with more pretensions to merit, contain no greater guarantee of professional ability than the L.S.A. The day when the Society of Apothecaries was regarded as a back-door to the profession has long gone by, and the licence can now only be gained by men well grounded in the theory and practice of medicine, surgery and midwifery. But the day has not yet gone by when invidious distinctions are, and will continue to be, drawn between this, that, and the other qualifying corporation, and regulations based on these supposed differences made by appointing bodies.

In affairs it is recognised that what is needed for successful administration is "men, not measures," and it is no less true in medicine that similar weight attaches to men, not qualifications. It is notorious that some of the most successful practitioners hold inferior degrees to some of their brethren who are striving to make two ends meet, although the studies of the latter contain gold medals and certificates galore. The only satisfactory way out of this unfortunate and distasteful comparison of the value of various diplomas is the "one-portal" system, which will place each man on the same level as his fellow in the eye of the State, and leave the question of his professional success to turn on his own ability, energy, and scientific attainments. In the leading states of America the M.D. of no University is regarded as conferring a right to practise; the qualification is ability to satisfy the examiners for the State licence. When a similar regulation is in force over here one will hear less of unseemly claims of competing bodies to represent all that is best in the particular department of practice they affect.

"Dagonet" and Death Certificates.

To certain individuals in every age an unwritten public licence is granted to tell home-truths to the multitude, and to mirror and gibbet their foibles and follies. This generation has given such a *carte blanche* to Mr. G. R. Sims, whose "Mustard and Cress" constitutes the sole intellectual and philosophical pabulum of numbers whom the pulpit and novel-with-a-purpose never reach. "Dagonet" is indeed a power, and every Sunday he delivers his message—as Mr. Stead would call it—clothed in a garb of humour that makes it presentable even to those who resent the trouble of thinking for themselves. Nothing in the sphere of the world's activity comes amiss to the genial dweller Opposite the Ducks; one day it may be the war, another the vagaries of his pony, and a third the virtues of a hair-restorer, whose simplicity of composition rivals the cacophony of its name. Recently Mr. Sims turned his facile pen towards the subject of death certification, and we regret that as his readers do not find the subject amusing he is going to drop it. It is hardly surprising that a lay audience fails to find entertainment in a matter—to them—so distasteful, but we should be glad to see Mr. Sims hammer into them the necessity for some radical changes in the happy-go-lucky way in which deaths are certified and registered. The case which called forth "Dagonet's" comments was one in which a woman had been attending a hospital, and though she had not been to the institution for nearly a month, the husband was granted a death certificate for the asking. An inquest was subsequently held, and the Coroner aptly remarked that for all the doctor knew the woman might have been murdered. So indeed she might, and so indeed might hundreds of others in the course of the year. The doctor's duty is only to state his opinion without fee or

reward, and it is for the authorities to take any further steps they may think necessary. But as uncertified deaths are registered on every side, the protection afforded by a doctor's opinion is not always forthcoming, and there can be no reasonable doubt that many a crime has passed undetected in a country which boasts itself of the highest form of civilisation.

The Discoverer of Alexander Selkirk.

PROBABLY there are but few who are aware that the originator of Dover's powder is the same person with the discoverer and rescuer of Alexander Selkirk. Thomas Dover, M.B., physician and filibuster, had probably as curious a career as any in the annals of medicine. A pupil of the great Sydenham, he had practised medicine at Bristol for more than twenty years, when at the ripe age of forty-eight, he took command, as captain of *The Duke*, of a buccaneering expedition round the world. This voyage seems to have been regarded as a holiday from his professional toil, for he cleared himself of all medical responsibility by carrying no less than four surgeons in his two small vessels. On the voyage he had notable adventures, of which the rescue of Alexander Selkirk is one of the least. He captured a Spanish prize of twenty-one guns, and "took by storm the two cities of Guayaquil, under the Line, in the South Seas." In addition to the loot, which he does not mention, he unfortunately carried away from Guayaquil the infection of plague, and in a few days had no less than one hundred and eighty men down with the disease. Assuming medical charge himself, he treated them with large quantities of diluted vitriol, and he reports that, in spite of the great severity of the disease, he lost only seven or eight men, "and even these owed their deaths to the strong liquors which their messmates procured for them." Some years after his return to England, Dover settled in London, where he acquired the nickname of the "Quicksilver Doctor," on account of his constant employment of mercury. His famous powder, curiously enough, was designed as a cure for gout, but there was no condition which the metal did not amend. Thus, for the cure of "the iliac passion," "you need go no further than to take a pound or a pound and half of crude mercury." Those who are interested in the life of this eccentric man cannot do better than read Dr. Knott's article thereon in the February number of the *Dublin Journal of Medical Science*.

Compulsory Vaccination in America.

AN interesting decision was given last month in the Supreme Court of the United States with regard to vaccination, a decision that gains in significance not only from the fact that it was given in the most democratic country in the world, but also from the reasons that guided the justices in arriving at it. The case in which it was given was an appeal from the Massachusetts Courts respecting a man named Jacobsen, who

refused to be vaccinated during an outbreak of small-pox on the ground that the operation, compulsorily enforced in accordance with the provisions of the law, was an infringement of his personal liberty—the argument that is so dear to the hearts of our own anti-vaccinationists. The justices of Massachusetts decided against Jacobsen, and the appeal to the Supreme Court confirmed the judgment. Justice Harlan, in giving the decision in the latter court, said that society based on the rule that each one was a law unto himself would soon be confronted with anarchy and disorder. Real liberty for all could not exist under the operation of a principle which recognises the right of each individual person to use his own will in respect to his person or his property, regardless of the injury that may be done to others. It is the acknowledged power of a local community to protect itself against an epidemic threatening the safety of all, and to exercise that right in particular circumstances and in reference to particular persons. This being the basis of the fabric of all society, the justices found that there were no special circumstances in the case that would exonerate the authorities from their duty to protect the welfare, comfort, and safety of the many. A plain statement of this kind, coming as it does from a foreign source, and one free from any kind of prejudice, puts the claim of violation of personal liberty in a light that should convince all fair-minded people. We fear, however, that it is the bugbear of vaccination that frightens our anti-vaccinationists and that they feel that any stick is good enough to beat it with, for the anti-vaccinationists for the most part are warm upholders of compulsory isolation when small-pox does occur.

Surgeon-General Eivatt and his Critics.

SURGEON-GENERAL EVATT has addressed a lengthy letter to the lay press in defence of his recent report on the Irish Medical Association. He commences by telling his readers the reasons for the varied nature of the report, and in particular for his attack on the Royal Colleges. It appears that these reasons are to be found in a resolution adopted by a "great national congress" of the Irish medical profession held on May 29th, 1838, and that it was the sentiments put forward at that meeting that influenced his comments and not the present condition of the Irish Poor-law Medical Service. His "whole report is directed to secure such union and to make such a national faculty" (as that suggested in 1838), "and to use the Irish Medical Association as the basis of that faculty, and there is no real difficulty in achieving such an aim bar the opposition, not of one college, as in 1838, but of both colleges, as in 1905. This opposition which sounds so strong is, when studied, essentially feeble." If we understand this somewhat obscure sentence aright, it conveys that there is no obstacle to the Surgeon-General's scheme "bar" that of the parties concerned and, we might add, or no support "bar" that of its originator.

It is impossible to criticise Surgeon-General Evatt's letter in the space at our disposal. It is badly expressed, verbose, and rambling. Its central idea is expressed in the extract which we have given, and the entire article is the evident work of a man who takes himself and his ideas more seriously than their respective importance warrants, and who has a burning desire to upheave whatever exists.—“However my report may be silenced, I am in no way silenced, and the ideas of my report can be spread broadcast over the land through the platform and the non-medical press. Great is the truth, and it shall prevail, and I claim that my report is the truth, however unpalatable it may be.” We understand that the said report contains much that is valuable, and much that can tend to effect the object for which the writer was brought to Ireland. It is a pity that so much good corn should be buried among so much chaff, but as the chaff has been carefully winnowed off and given to the press, we think that the Irish Medical Association will be ill-advised if it does not bring forth the corn also.

Over-Worked Nurses.

ONE of the difficult problems that Poor-law guardians have to deal with is that of providing adequate nursing for the inmates of infirmaries without throwing too great a cost on the local rates. Now that nursing is a skilled art and not a slovenly makeshift, it is incumbent on all those responsible for the welfare of the sick to place them under nurses who are not only willing, but competent, and as such nurses are a comparatively expensive luxury, the guardians in many cases do with as few of them as they can possibly get along with. The consequence of this policy of cheeseparing is that the unfortunate inmates often get a minimum of attention, and the still more unfortunate nurses are worked off their legs. While this is so “scandals” are bound to occur, and a scapegoat is only too often forthcoming in the shape of a nurse who has been set to do the work of two or three persons. In a case in which an inquest was held recently on the body of an old woman who some little time before her death had sustained a fracture of the clavicle, it came to light that the whole of the infirmary of which she was an inmate was left at night in charge of three nurses. The infirmary contained a hundred and twelve beds, and none of the nurses concerned had completed their training. It was alleged in evidence that the fracture had been said by the old woman to have been caused by rough handling by one of the nurses—a young probationer of a few months' standing. There was no other evidence against the nurses so the jury found an open verdict, and, we are glad to see, added that in their opinion the infirmary was under-staffed and that a qualified nurse should be in charge at night. Many cases similar to this in some of their details have come under our notice, and for the sake of humanity it is much to be wished that the Local Govern-

ment Board would insist on a substantial minimum number of qualified nurses being maintained at all the infirmaries. It is not fair that the blame when scandals occur should be cast on women who are worn out with trying to do an impossible amount of work under impossible conditions.

President Roosevelt and the Birth-rate.

It is not long since, as our readers will remember, an interesting discussion took place in our columns on the causes of the diminishing birth-rate in this and other countries. It has been held by some that a diminishing birth-rate is not in itself a sign of a decadent condition of society, but that it may be, as Malthus suggested, an attempt to regain an economic equilibrium. This is not, among thinking people, the received opinion, and however individuals may govern their own conduct, they are generally willing to agree that decrease of the birth-rate is a sign of selfishness on the part of the possible parent, and a danger alike to the morality and physical health of society. In these countries the medical profession as a whole has set its face against all practices tending to prevent conception, and there can be little doubt that such practices are, in modern civilised communities, the main cause of the decreasing birth-rate. Those who agree in this opinion will be grateful to President Roosevelt for the manly and sensible words addressed by him the other day to a congress of mothers. “The man or woman,” he is reported to have said, “who deliberately foregoes the supreme blessings of children, whether from viciousness, coldness, shallow-heartedness, self-indulgence, or mere failure to appreciate the difference between the all-important and unimportant, why, such a creature merits contempt as heartily as any that is visited on the soldier who runs away in battle.” The homely morality and good sense of the President's remarks should help to maintain a healthy public opinion on this most important of social questions.

Professor Osler's Farewe

It is a curious fact that the only part of Professor Osler's valedictory address to Baltimore University which was cabled to this side of the Atlantic was his joke regarding the chloroforming of aged men. When one reads the whole oration, (a) however, one finds that he has touched on many points of interest to university life, and that what he said was full of rich suggestion. Declining to give any explanation of his personal reasons for his passage from Johns Hopkins to Oxford—a movement which must have puzzled many—he dilates on the advantage of itinerant university staffs. Too long connection between professors and college is harmful to both. On the one hand, too long occupation in the same round of duties tends to breed self-satisfaction, to narrow one's outlook, and to foster a deadening local spirit. Transferred to fresh fields, new surroundings, and

(a) *Journal of the Amer. Med. Assoc.*, March 4th, 1905.

other colleagues, a man gets a fillip which lasts for years. As the mental activity of the professor is the life of his class, so it is to the interest of the university that no member of the staff should remain long enough to get stale. Even when the loss of a professor seems a serious blow to a college, it is generally in the end an advantage. Professor Osler went on to suggest, in humorous vein, the establishment of an international university clearing-house, which should arrange the periodic interchange of teachers between the different schools. While there is much truth in Dr. Osler's remarks, we fear that it is impossible to carry out his suggestions to any great degree. In these countries, at any rate, most medical teachers are dependent on their private practice for a living, and once a man gets rooted in practice he cannot stand transplantation. More easily followed is Dr. Osler's advice to young men to travel much. Not only does he recommend post-graduate visits to centres of research and study, but during undergraduate days he thinks it is well to spend one year or two of the necessary course at some school other than that where the other years have been spent.

Zomotherapy in Tuberculosis.

AMONG the different modes of treatment advocated from time to time for pulmonary tuberculosis, the practice of administering freshly prepared meat-juice, or even raw meat itself, is one which is deserving of a more extensive trial. The sustaining and nourishing properties of the fluids of raw flesh have long been known, but for various reasons this natural liquor carnis has been generally discarded in favour of the so-called extracts of meat, except by a few who believe in its virtue. The introduction of the term "zomotherapy" by Richet (*somos*, meat-juice) has opened up quite a new field of dietetics, and the administration of raw meat in cases of pulmonary tuberculosis has formed the basis of a careful research by Dr. J. Galbraith, a summary of whose work up to the present has recently been published by Dr. R. W. Philip, (a) of Edinburgh. Thus, it was found that there was a marked increase of hæmoglobin, an improved intestinal metabolism, and a higher degree of digestive leucocytosis as a result of taking meat-juice. Another well-marked feature was that a larger amount of nitrogen was retained in the body. From the clinical aspect Dr. Philip observed an amelioration all round in the symptoms, among which the most noticeable were an increase in weight, a diminution of the myotatic irritability so commonly seen in phthisis, and in some cases a tendency towards the reduction of pyrexia. Any preliminary distaste for raw meat was, as a rule, speedily overcome by the patients, many of whom, indeed, acquired quite a liking for it. The method of preparation is of great importance, for unless it be freshly made before

each administration, putrefactive changes are apt to supervene which may cause irritation in the stomach. We believe that it still remains the happy privilege of the clinical assistants at one of the London hospitals to prepare meat-juice after the most approved fashion for the use of the patients in the wards to which they have been appointed.

THE annual Board of Governors of St. John's Hospital for Diseases of the Skin will be held in the "Pinafore" Room of the Savoy Hotel, on Tuesday next, March 28th, at 4.30. The Earl of Chesterfield will preside.

The French Minister of the Interior has just nominated a new committee called "Comité Consultatif d'Hygiène Pénitentiaire," to which will be referred all questions of prison hygiene.

IN response to petitions presented by the London School of Tropical Medicine in February, 1904, the Senate of the University of London has decided to institute a sixth branch of study—namely, tropical medicine—in which candidates may be examined for the M.D. degree, and has admitted the London School of Tropical Medicine as a school of the University in the subject of tropical medicine.

PERSONAL.

THE Duchess of Albany has kindly consented to attend the annual meeting of the governors of the National Hospital for the Paralyzed and Epileptic, Queen Square, London, to be held at the hospital to-day at 3 o'clock.

SIR SAMUEL SCOTT, Bart, M.P., has been elected chairman of the Committee of Management of Queen Charlotte's Hospital in succession to the late Earl of Hardwicke.

It is proposed to give a dinner in honour of Dr. F. Roberts by his former house physicians. Dr. Roberts has held the post of physician at University College Hospital for twenty-five years.

DR. HENRY DAVIES, of Bryn, has been appointed to succeed Dr. Sinclair as medical officer to the Abergwynfi and Blaengwynfi Collieries. There were forty-five candidates for the appointment, which is worth £400 per annum.

THE late Alderman Thomas Llanwarne, J.P., of Hereford, has bequeathed £500 to the trustees of the Hereford municipal charities, for the benefit of the alms people, and £200 to the Hereford General Hospital.

THE late Mr. John Gulson, of Coventry, has bequeathed £1,000 to the Coventry and Warwickshire Hospital and £500 to Coventry Nursing Institution.

THE following appointments are notified in the "Gazette": Surgeons—C. J. Boucher to the *Five Queen*, for disposal; A. F. Fleming, to the *Vivid*, for disposal; C. B. Fairbank to the *President*, for three months' hospital study; and J. Verdon to the *Vernon*.

MR. G. H. MAKINS, C.B., F.R.C.S.Eng., and Mr. Charters J. Symonds, M.S.Lond., F.R.C.S.Eng., have joined the consulting staff of the Bolingbroke Hospital, Wandsworth Common, S.W.

(a) *Practitioner*, January, 1905.

It has been proposed to entertain Dr. Fowler at a dinner in recognition of his success in meeting the disgraceful charges brought against him in recent divorce proceedings. The medical profession of Croydon and district met last Monday at the Public Hall, Croydon, to make all necessary arrangements.

MR. T. S. P. STRANGEWAYS, of St. John's College, has been appointed the first Huddersfield Lecturer in Special Pathology on the new foundation recently established in the University.

MR. R. T. NEWSTEAD, external examiner in entomology in the University of Edinburgh, has been appointed lecturer in economic entomology and parasitology in the Liverpool School of Tropical Medicine.

SURGEON-MAJOR A. A. WATSON, has been promoted to be Surgeon-Lieutenant-Colonel in the Army Medical Reserve.

THE KING has sanctioned the following promotion in the Order of the Hospital of St. John of Jerusalem in England—viz., Joseph Dallas Pratt, M.D. Dub., F.R.C.S. Irel. (from Honorary Associate), to be Knight of Grace.

THE Right Hon. Joseph Chamberlain, M.P., has consented to preside at a banquet to be held at Hotel Cecil, May 10th, in support of the London School of Tropical Medicine. The Duke of Marlborough is chairman of the dinner committee.

THE valuable and extensive exhibit of pathological specimens at the Garcia Centenary meeting of the Laryngological Society of London, held on Friday last, was selected and arranged by Dr. Pegler, Curator to the Society.

THE widow of Dr. Begley, late medical superintendent of Hanwell Asylum, has bequeathed £1,000 to Trinity College, Dublin, to augment the legacy of her late husband for the establishment and endowment of four medical scholarships, besides several legacies to other medical institutions.

MRS. ELLEN WARE of Tunbridge Wells, has bequeathed £500 each to the General Hospital of that town and also to Guy's Hospital, St. Thomas's Hospital, the Soho Hospital for Women, and the Hospital for Incurables.

THE Goldsmiths' Company has contributed a second donation of £500 towards the rebuilding of St. Bartholomew's Hospital, the money to be devoted to the construction of the new out-patients' department. The guild's previous donation towards the rebuilding fund was £2,000.

THE Memorial Committee of the fund for perpetuating the memory of the late Sir Wm. Mitchell Banks have contributed £1,500 for the purpose of founding a Mitchell Banks Lectureship in Medicine in the University of Liverpool.

DR. ARTHUR R. CUSHNY has been appointed to the Chair of Pharmacology and Materia Medica at University College, London. He graduated with highest honours at Aberdeen in 1889, carrying off the Thomson Travelling Scholarship and Murray Medal, besides other distinctions.

Royal Army Medical Corps.

MAJOR C. W. R. HEALEY and Major J. H. Daly are posted to Dublin and Queenstown respectively. Lieutenant-Colonel S. Westcott, C.M.G., is appointed Medical Inspector of Recruits to the Northern Command, at York, and Lieutenant-Colonel A. F. Russell, C.M.G., to the Eastern Command, at London. Surgeon General W. Donovan, C.B., left England on March 4th for South Africa to take up his duties as Principal

Medical Officer on the Staff of Lieutenant-General Sir Henry Hildyard at Pretoria. Lieutenant-Colonel H. O. Trevor is appointed Medical Inspector of Recruits in the Aldershot Army Corps. Colonel J. F. Routh, who has been serving on the strength of the Aldershot Command, has left England for India to take over administrative charge of a district on promotion. Colonel J. Magill, C.B., has left England for Egypt to take up the duties of Principal Medical Officer of the army of occupation, on appointment, in succession to Colonel W. A. May, C.B.

Special Correspondence.

[FROM OUR OWN CORRESPONDENT.]

BELFAST.

FORSTER GREEN HOSPITAL FOR CONSUMPTION.—The annual report of this hospital, which has just appeared, contains some interesting matter concerning the medical work done last year. The intern patients numbered 193, of whom 12 per cent. were slightly affected on admission, 31 per cent. moderately affected, 37 per cent. seriously affected, and 20 per cent. very seriously affected. The condition on leaving after an average stay in hospital of 14 weeks was 46½ per cent., much improved, 35½ per cent. improved, and no improvement in 18 per cent. Weight was gained by 134 patients, lost by 10, while 17 remained stationary. The average gain was 10.1 lbs., and the greatest gain 62½ lbs. The average temperature on admission was 100.4, and on leaving, 99.2; the average respirations 24.7 on admission, and 22.2 on leaving. The first table, showing the condition on admission, is an index of the influence of the lay members of the Board of Management in the admission of patients. The medical staff never ceases to emphasise the fact that it is in the early stages that real and lasting good can be done, but, as usual, the laymen use their influence to dump down in the hospital the cases which appeal most to their misdirected sympathies—that is, those who are in advanced stages of phthisis, to whom only temporary relief can be given.

SOCIETY FOR PROVIDING NURSES FOR THE SICK POOR.—The annual meeting of this most useful society was held in Belfast last week, the Lord Mayor presiding. Drs. David Wilson, S. B. Coates, J. Lynas, G. A. Hicks, and Morrison testified either by letter or speech to their personal experience of the excellent work done among the poor of the city. The report stated that during the year the nine nurses of the society had attended 1,116 cases, and had paid 35,238 visits. No less than 224 of the cases were of phthisis. In the great majority of cases help is given in the form of nourishment, or a little money towards the rent if it is the bread-winner who is laid aside.

COUNTY ANTRIM INFIRMARY, LISBURN.—The annual report just issued by Dr. G. St. George shows that during the past year he had 320 intern patients under his care, and 651 extern. The accidents treated numbered 297, of which 40 were detained in hospital. There were 140 operations, with two deaths. The amount of work done is a little less than in the year before, due to the fact that Dr. St. George was disabled for some months by septicæmia.

COUNTY DOWN INFIRMARY, DOWNPATRICK.—In his annual report of the hospital under his care, Dr T. M. Tate states that the number of intern patients treated was 585, and the extern, 799. The average number of beds occupied was 45, and the average cost was 2s. 4½d. per day per patient. The average cost of each bed occupied was £43 16s. 7½d.

RESIDENT PUPILS AT THE ROYAL VICTORIA HOSPITAL.—Considerable difficulty has arisen at the Royal Victoria Hospital in obtaining students to fill the vacancies in the resident pupilships as they arise. This difficulty is said to be due to the charge for board, which is now fixed at a guinea per week, and which the students object to paying. In the old hospital the charge was £15 for six months, so that the charge has been about doubled. As the pupils are a necessary

part of the internal economy of the hospital, some change will probably be made in the present arrangement.

Correspondence.

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

LONDON HOSPITAL APPOINTMENTS AND THE ASSOCIATION OF MEDICAL DIPLOMATES OF SCOTLAND.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I am a member of the Association of Medical Diplomates of Scotland and in sympathy with its aims. It is for this reason that I wish to make some comment on your account of its meeting on March 10th, when, I regret, I was unable to be present. The special matter under discussion—the exclusion of provincial qualifications from hospital appointments in London and elsewhere—is an important question and one capable, I think, of being satisfactorily settled in time, if this desirable end be kept steadily in view and just and practical means taken to attain it. Such a settlement can never, I believe, be reached by any form of compulsion, but only by the mutual agreement of all the bodies concerned. The way to that desirable consummation will not be rendered more easy by the imputation of unworthy motives to one body as distinguished from another.

If, moreover, we agree to the contention of one speaker at the meeting, that the sole qualification for holding the coveted appointments should be the fact of being on the *Register* of qualified practitioners, without any regard being had to the quality of the qualification, I do not suppose many are sufficiently sanguine to think that the object the Association has in view is likely to be realised within a measurable period. It would, I imagine, be scarcely advisable to urge that the qualification most easily obtained—whatever that may be—should be made the criterion of eligibility for hospital appointments.

The "able" and "original man" and the "genius," for whose advancement some concern was expressed at the meeting, is usually pretty well able to take care of himself, and I do not think we need unduly mourn his hampered recognition. Such men are not common, and it is safer to turn our thoughts towards the average man who will much more frequently be a candidate for the posts in question.

The qualifications required for certain positions in various countries have come to be demanded during the evolution of those appointments. For some posts in England, even now, I believe the L.S.A. is a *sine qua non*. I am under the impression, moreover, that the Fellowship of the Royal College of Physicians in Edinburgh is essential for candidature for some posts in that city; I do not know whether there is any stipulation in Ireland discriminating in favour of an Irish qualification. If there be not, Ireland is exceptional in this respect.

I agree with one of the speakers at the meeting, who remarked that "there was no need to make any invidious comparisons as to the relative value of London and provincial qualifications." What is necessary, however, is that for the most responsible positions the highest qualifications should be required, not the lowest, and this notwithstanding the loss to humanity of an occasional "genius" whose strength may not lie in passing examinations—this vagary of genius being one of the points referred to at the meeting.

The practical question then seems to be—How is an acknowledgment of the equal value of all the higher qualifications to be conveyed to the minds of the electors to the coveted posts throughout the kingdom?

The method which suggests itself to my mind is, that there should be established a Censors' Board or Board of Visitors to the examinations for the higher qualifications in the three countries, possibly to embrace in time—in these Imperialist days—also the

Colonial centres. These should be representative men chosen by their own colleges and approved not by some central body, but by the other colleges. Three or more visitors in the meantime each, or each group representing one of the components of the United Kingdom, should attend the examinations for the higher qualifications in England, Scotland, and Ireland respectively. "Gallant little Wales" might even be represented separately if the Dragon Principality felt it necessary to emphasise its national independence under the circumstances. The satisfaction of such Censors or Visitors would, I believe, be regarded as sufficient by authorities throughout the kingdom, and thus practically a one-portal system for the higher qualifications would be introduced and the privileges of the several corporations conserved at the same time. The onerous duties of the General Medical Council could then be dispensed with, and each Corporation of University left to be its own censor. Moreover, with adequate powers for legal action.

It is thus, Sir, that I venture to suggest that the Association of Medical Diplomates of Scotland is most likely to attain *this* object of its legitimate ambition.

To every scheme objections can be urged, and to that I have ventured to propound I doubt not many will be advanced if you favour me with space in your columns for this letter. But I do not think any insuperable difficulty need arise; and should my proposal meet with favour in the eyes of the Association of Medical Diplomates of Scotland, I feel sure that its practical application could be secured from all the bodies interested. The only house left tenantless would probably be the domicile of the conglomerate in Oxford Street. In that event I do not think the wail of the disconsolate muses would be heard through the traffic which rumbles past its door.

I am, Sir, yours truly,

ALEXANDER MORISON.

14 Upper Berkeley Street, W., March 17th, 1905.

THE TIMES AND THE MEDICAL PROFESSION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Among the readers of *The Times* there must be many thousands who, like myself, deplore the signs of decadence in some important directions which the great paper has, within the last year or so, displayed. Hitherto it has indisputably claimed in every respect the title of leading journal—leading not only among British newspapers, but among those of the entire world.

The great qualities which have gained for *The Times* its unique position have been long acknowledged, and especially by serious students of contemporary history. In its pages have always been found the most accurate and complete daily narrative of the affairs of the wide world, and the best informed account of international politics. The literary character of its writings throughout has been invariably of the highest standard, whilst its special articles on science, art, literature, and sociological subjects have almost invariably displayed intrinsic evidence of the authors' valid claim to attention and respect.

The superiority of *The Times* over all its contemporaries has been, until recently, nowhere more conspicuously displayed than in its advertising columns. Puffs and advertisements printed so as to lead the ingenuous reader to take them for editorials, or, at least, to bear the editorial endorsement, have been unknown. *The Times* has also hitherto always appeared to acknowledge and act upon the fact that there is little difficulty in recognising medical quackery in any form, and no difficulty in discriminating the infamous rogues, whether unqualified practitioners fraudulently pretending to be legally qualified, or concoctors and vendors of nostrums and panaceas who devote themselves to making money by the plunder of suffering humanity. *The Times* has always up to now given ample proof of its right motives in this matter by refusing, at vast pecuniary sacrifice, to admit advertisements of quacks, whose announcements have found

a place in all other newspapers. It is the admission of this latter class of advertisements which is now forming a foul blot on the fair fame of *The Times*.

In a leading article in October, 1893, *The Times* deplored "The enormous expenditure upon quacks and quack medicines which undermine the health of so many victims and which brings about the evil of maintaining in luxury some of the most complete of the impostors who are parasitic upon modern civilisation."

In another leading article in October, 1897, on the medical profession, *a propos* of the opening of the Medical Schools, the following passage occurs:

"The whole enormous system of quack medicines and quack advertisements is conducted on the lines of implied disparagement of doctors; and druggists, who sell the advertised preparations at a large profit, lend a great, if not a tacit, influence in the same direction."

The managers of *The Times* can easily satisfy themselves that the previous statements of their Editors are equally applicable to the present day. They can easily learn that 95 per cent. of advertised quack medicines are frauds useless for their purposes and hurtful in many ways. They might begin by asking their recent most able contributor on infantile mortality to what extent infant "soothing" medicines form a factor in the terrible preventable mortality he described. They might then inquire among physicians how far drunkenness among women is encouraged by the use of "nerve tonics" containing large quantities of alcohol. They would find, further, that nearly all the pills advertised to cure single or many ailments have as their sole potent ingredient a portion of some cheap drastic purgative, and that the use of these pills, besides very often giving rise to disastrous delay in serious disease (an equally common result of reliance upon all other quack medicines) is the common cause of an extremely prevalent disease of the lower bowel. They may easily learn the nature of the coarse frauds, cruel and injurious, carried on by epilepsy curers, obesity quacks, and rupture, consumption, and cancer quacks.

It is, however, remarkable that the managers of *The Times* still fully recognise their responsibility with regard to at least one class of announcements of a medical kind. The column devoted to nursing and massage advertisements is now always headed by a notice to the effect that these "are only accepted on recent certificates of a physician or surgeon," etc. The abuses practised under the cloak of sham nursing and massage establishments are of course, notorious, but no one knowing the facts would suggest that the evils arising in this way are in any way comparable in importance to the injury inflicted upon the public by the sale of a single fraudulent quack medicine. Then, again, the ingenious reader observing the notice referred to may naturally infer that all the other medical advertisements in the papers must be similarly vouched for, or at least that the appearance of the advertisements in *The Times* must constitute a guarantee of their *bona fides*. The astute gentry who carry on the quack medicine trade are certainly not oblivious of this fact, and are evidently willing to pay for the advantage accordingly.

I am, Sir, yours truly,

HENRY SEWILL.

Cavendish Square, March 8th, 1905.

MEDICAL ADVERTISING OR WHAT?

To the Editor of THE MEDICAL PRESS AND CIRCULAR.
SIR,—May I call your attention to these announcements in to-day's *Daily Telegraph*?

"THE HON. OLIVER BORTHWICK."

"We regret to say that the health of Mr. Borthwick has for some time given cause for anxiety to his family. Although it improved after an operation last September and subsequently benefited by the air of Hampstead, it has lately shown some recurrence of unfavourable symptoms. In consequence of this a consultation was

held by his medical advisers last Friday. The following are the consequent bulletins:

"After consultation with Mr. Watson Cheyne and Sir Alfred Fripp, it was decided to perform an operation. On Saturday morning Mr. Charters Symonds successfully performed the desired operation at Phyllis Court, Hampstead. The patient's condition is so far satisfactory.

"W. HALE WHITE.

"March 18, 1905." "W. H. NEALE."

"Mr. Borthwick has passed a fair night. His strength is maintained as well as could be expected after such a severe operation.

"W. HALE WHITE.

"CHARTERS SYMONDS.

"March 19, 1905." "W. H. NEALE."

"Mr. Borthwick has passed a quiet day. The strength is maintained, and the pulse is good.

"CHARTERS SYMONDS.

"March 19, 1905." "W. H. NEALE."

I am only a "man in the street," and I am ignorant who the Hon. Oliver Borthwick is. I do, however, know some of the distinguished names in this announcement. I must not call it advertisement—might I suggest the following general heading to announcements of this kind, which are becoming so common in the newspapers:—

"For the better arrangement of advertisements relating to medical matters, it is hereby notified that all surgical operations and the operators' names will appear in future on column —, page —."

The profession and the public will then know where to look for them, the privacy of operations being no longer necessary.

I am, sir, yours truly,
AN OLD-FASHIONED PRACTITIONER.

Literature.

RECENT BOOKS ON DEFORMITIES.

BARWELL ON LATERAL CURVATURE OF THE SPINE. (a)

We have perused the pages of this little work with very great pleasure as it contains much valuable information concerning the subject of which it treats. Mr. Barwell has been long known as an able orthopædic surgeon and in this sixth edition of his work he lays considerable stress on the importance of directing attention to the deforming influence of certain pelvic malpostures and deviations, as the frequent initial cause of lateral curvature of the spine. He has advocated special treatment so as to directly affect this portion of the bony framework and thus effect a cure in the proper and necessary direction. The book will well repay a careful perusal.

JACKSON CLARKE ON CONGENITAL DISLOCATION OF THE HIP. (b)

This monograph contains many interesting statements of which the following is an example. As the author mentions in his introductory remarks, "Congenital dislocation of the hip-joint is no longer to be regarded as an incurable affection—that is, an average case is curable. To many this may appear a somewhat daring assertion, but from my own experience I can unhesitatingly make it. On January 14th, 1903, Lorenz operated on a patient of mine, a girl, aged nearly six years, with typical double congenital dislocation (Case I., p. 17). The after-treatment has been carried out under my own direction. That child is now cured

(a) "Lateral Curvature of the Spine and Pelvic Deviations." By Richard Barwell, F.R.C.S., Consulting Surgeon, Charing Cross Hospital; Surgeon, Cripples Home, &c. Sixth Edition, Pp. 108; Illustrations, 42. Price 3s. net. London: Baillière, Tindall and Cox. 1905.

(b) "Congenital Dislocation of the Hip." By J. Jackson Clarke, M.B., F.R.C.S., Surgeon to the North-West London Hospital, and to the City of London Orthopædic Hospital. Second Edition. Pp. 37. Price 1s. 6d. net. London: Practitioner, Ltd. 1905.

having the heads of both femora firmly established in the acetabula and she walks strongly and well." Since the visit of Lorenz in January 1903, to this country and his demonstrations in Liverpool and London much has been done in the treatment of these cases. We advise all interested in this subject to study Mr. Jackson Clarke's paper, which is very short and very readable.

BENNETT ON RECURRENT EFFUSION INTO THE KNEE-JOINT. (a)

THIS small and readable book by Sir William Bennett consists of a lecture which was delivered in St. George's Hospital and subsequently appeared in the pages of the *Lancet* (January 7th, 1905). It is now reprinted in separate form with some additional illustrations and a few other minor alterations. The subject of internal derangement of the knee-joint is so important that all information bearing on the injury from the pen of Sir William Bennett ought to prove useful, and we have no hesitation in recommending the perusal of his practical remarks.

CAIRO OF TO-DAY. (b)

OF late years the number of travellers to Egypt in pursuit of pleasure or health has immensely increased, nor is this to be wondered at in view of the numerous objects of unrivalled archaeological interest there to be seen, to say nothing of the climate, which is the antithesis of the English. In this work the author deals with the objects of interest within easy reach of Cairo and incidentally with the city itself, and the political history and present condition of "Egypt under the English," a state of things that he concedes to be anomalous in the extreme." If the Egyptian climate be admirably suited for a winter residence the author is unable to say as much for Cairo, which, he observes, "cannot be unreservedly recommended as a health resort pure and simple." Obviously, a city with half a million inhabitants provided only with "an appallingly primitive and insanitary system of drainage" seems the last place to which the health seeker should be sent. The prospect is held out that in years to come, when a costly system has been carried into effect, Cairo "will very likely be one of the healthiest places of residence in the world." Cairo however, is not Egypt, and there are some four or five health resorts to say nothing of the Nile, where invalids are catered for, more or less.

The author has given us a highly readable guide to Cairo and its neighbourhood, written in irreproachable English and with perfect impartiality. He holds aloof from anything of the nature of a "puff," and his paragraphs are excellent synopses of historical, geographical, and political information. The introductory chapter on the means of getting to Egypt is elaborately complete, and will save intending travellers much anxious poring over time tables, &c., and steamer services. It is, in fact, the type of what a guide-book should be—laconic, scholarly, and reasonably humorous, duly provided with maps, plans, and illustrations.

BELL ON CANCER. (c)

A CAREFUL perusal of Dr. Robert Bell's pamphlet on cancer leaves one still in some doubt as to what are his exact views on the subject. They evidently differ so much from the received opinions that it is difficult to make them quite clear in two-score pages. As far as we can judge, Dr. Bell's main thesis is that cancer is a constitutional disease, whose main feature is an alteration in the nutrition of the cell. "So long as cell development and growth are active, malignant disease is not liable to assert its presence. It is when

the cellular tissue has ceased to increase its numerical strength . . . that malignant instead of normal metamorphosis takes place." Dr. Bell overlooks the fact that no tumour formation can take place without a hyperactivity of cell formation, which always precedes cell metamorphosis. The liability to malignant metamorphosis is, in his opinion, due to a toxin circulating in the blood, which has escaped the antitoxic action supposed to be exerted by the thyroid gland. The practical result from the theory is that cancer requires constitutional treatment rather than local. The general treatment Dr. Bell would apply is, we gather, merely hygienic and dietary. It should attempt "measures which will prove effectual in restoring disabled controlling organs," of which the thyroid gland is the principal. Surgical treatment of cancer is condemned as merely symptomatic and "never giving permanent relief." On the other hand, the author applies formalin solution to superficial growths on the ground that it tends to lower the vitality of the diseased cells. The brochure contains many points of interest, but can hardly be regarded as convincing in its argument, or safe as a guide to practice.

DISEASES OF CHILDREN. (a)

THE publication of these lectures, which appeared serially in the *Clinical Journal*, in permanent form, will be welcomed by those who read them as they were delivered, and we venture to predict that in their new shape they will attain a large circulation. Dr. Hutchison has succeeded, within comparatively small compass, in giving the essentials of his subject with his accustomed conciseness and grasp of due proportion. While we look in vain, therefore, for discussion of pathological problems, a knowledge of which, however interesting to the specialist, can be dispensed with by the practitioner, our attention is at once focussed, first on the diagnosis and natural history, and secondly on the treatment of diseases in children. One of the best chapters is that on Infant Feeding, and the reader will turn to it with relief, knowing that here he will find none of those complex formulæ and percentages with which the labours and writings of American physicians have made us not familiar, perhaps, but at least acquainted—formulæ whose value we by no means under-rate, but which are both unnecessary and unattainable in the climatic and present social conditions of this country. Dr. Hutchison's rules are simple, and if intelligently applied half the difficulty which some medical men seem to have in feeding delicate babies will vanish. "You should not lightly change from one kind of food to another," is an oft-neglected axiom, the importance of which we heartily endorse. The table showing the composition of patent foods is a most useful adjunct to this chapter. The chapters on digestive disorders are also particularly good; we are glad to notice that Dr. Hutchison emphasises the need for being on the look-out for congenital pyloric stenosis, which is by no means very rare; the value of subcutaneous saline injections in acute diarrhoea is also pointed out. The chapters on rickets, syphilis, scurvy, rheumatism, and functional nervous disorders are all worthy of special mention, and the author has wisely devoted whole lectures to the medical aspects of adenoids (laying stress on their occurrence in young infants, as well as later) and to the very important subject of imbecility, which, so far as infants are concerned, comes much more into the work of the pædiatrist than of the alienist. It is greatly to be desired that more interest should be taken by general practitioners in mentally deficient children, for there is no doubt that a little skilled guidance given to the parents of these unfortunates would do something to improve the less severe cases, and in the worst would at least help the mother to bear what is, especially among the less well-to-do, one of the bitterest of burdens. The book, which is dedicated to Dr. John Thomson, is

(a) "Recurrent Effusion into the Knee-Joint after Injury; an Analysis of 750 Cases." By Sir William Bennett, K.C.V.O., F.R.C.S., Senior Surgeon to St. George's Hospital, Surgeon to King Edward VII Hospital, &c., with 11 illustrations. A Clinical Lecture delivered at St. George's Hospital. Price 3s. 6d. net. London: Longmans, Green and Co. 1906.

(b) "Cairo of To-day." By E. A. Reynolds-Ball, B.A., F.R.G.S. Author of "Mediterranean Health Resorts," &c., &c. Fourth Edition. London: A. and O. Black. 1906.

(c) "The Cancer Problem in a Nutshell." By Robert Bell, M.D., F.F.P.S., &c. London: Glazier, 1906. Price 1s. Pp. 39.

(a) "Lectures on Diseases of Children." By Robert Hutchison, M.D., F.R.C.P. Pp. xii and 338. London: Edward Arnold. 1904.

illustrated by a large number of original photographs, most of which are excellent; its style is so direct and simple as to make reading it a pleasure, and it seems to us in all respects a most admirable guide to the subject with which it deals.

BRIGHT'S DISEASE. (a)

It is with great interest that we have read this book, in which the author gives an account of his method of surgical interference in the treatment of Bright's disease. The first two-fifths of the book are taken up with reprints of the various papers on this subject that the author has already published; most of these appeared in the American medical journals. The latter three-fifths of the book consist of a minute history of all the patients operated upon up to the end of the year 1903, and a summary composed of tables of analyses of these cases and conclusions to be drawn therefrom. This method of arrangement has led to a good deal of repetition not only in the history of the cases but also in the general subject-matter. The first part of the book is rather marred by a lengthy discussion on the subject of priority in the surgical treatment of Bright's disease; in this Dr. Edebohls appears to fully justify his claim of having been the first to deliberately perform an operation on the kidneys for the express purpose of attempting the cure of this disease.

The number of patients submitted to operation is seventy-two, of these sixty-nine have been followed up to the present date or to the time of their death. This alone gives the reader (who has had any experience of the trouble involved in following up operation cases) some idea of the care and labour that Dr. Edebohls has taken with this work.

In connection with most of the histories, which are very full, tables of analysis (both quantitative and qualitative) of the urine are appended. The discovery of the efficacy of decortication of the kidney, for the amelioration or cure of Bright's disease was like many other discoveries to a large extent accidental. Dr. Edebohls was in the habit of fixing a floating kidney by decortication, and having had occasion to perform nephrorrhaphy on five patients, who had both the symptoms and physical signs of Bright's disease, he noticed that these were greatly improved, and finally disappeared after the operation; in the sixth case, therefore, he operated with the purpose of attempting to cure the Bright's disease as well as of fixing the kidney. These cases may be objected to on the ground that the disease was caused by the mobility of the kidney, and that fixation and not decortication was the cause of the cure. However, in many of the later cases where a cure resulted, there was no mobility of the kidneys before operation.

Of the seventy-two cases three were lost sight of, seven died shortly after the operation; twenty-two died at a time more or less remote from the operation; and forty survived to the present day.

The seven patients who died shortly after the operation were all in the last stages of the disease when operated upon, and in no case could the operation be said to have hastened death by more than from a few days to a couple of weeks; in fact, it was only at the patients' own earnest entreaties that Dr. Edebohls consented to operate at all in these cases. Of the other twenty-two deaths, nine were due to causes which were in no direct relation to nephritis; nearly all of them experienced improvement if not actual cure, though some of them afterwards suffered a relapse of the symptoms due to disease of their kidneys. Of the forty survivors, three are unimproved, twenty are improved and seventeen are cured.

These facts speak for themselves. That the patients were really suffering from Bright's disease (meaning by this some form of chronic nephritis) is definitely shown by the symptoms and examination of the urine, as well

as by the appearance of the kidneys at operation and in a few cases by the microscopical examination of small portions of the kidneys removed at operation. We must, however, make exception of two cases of eclampsia cured by this operation which are included in the seventy-two cases. Two facts appear to us as strong confirmation of the genuineness of the advantages claimed by Dr. Edebohls for his operation. First, that ten of his seventy-two patients were physicians, and two others were close relatives of physicians; Secondly, one patient was refused for life insurance, owing to the presence of Bright's disease, but fourteen months after operation he was granted a conditional policy in one of the three large New York insurance offices.

The book appears to be a very dispassionate and fair account, no case being claimed as a cure unless the urine remained free from albumin and casts, and the daily output of urea was normal, or approximately so, for a period of at least six months, and the patient was relieved of the symptoms of chronic Bright's disease from which he suffered before operation.

There is one important point that is conspicuously lacking in the book, and that is details of the changes occurring in the kidneys after operation, as shown by *post-mortem* examinations and experiments on animals. The difficulty of causing chronic nephritis in the lower animals, and therefore of getting diseased kidneys in place of normal ones to experiment with, is the reason given for the latter omission; and in regard to the former the author holds out a promise of a paper at an early date by Dr. Larkin, in which he will describe the conditions found in four kidneys removed *post-mortem* from two patients operated on by Dr. Edebohls.

"MR. WATCH, PAWNBROKER." (a)

DR. DABBS has gained distinction as a writer, versatile and vigorous, with sincere sympathy with human suffering, and keen insight into the romance of human existence. Many of his works, while manifesting much of the true intuition of the poet, are securely balanced by sound psycho-medical teaching. He knows the humour of human life and the scent of the country clings to his portraits of simple folk. His talents should be devoted to fixing the now almost forgotten country practitioner of by-gone years. In the present volume he gives us a series of stories of the police-news type, all of which are sadly lacking in ingenuity of plot and in many instances are devoid of any force. The volume shows evidence of haste in construction and has apparently been compiled merely to serve as a make-shift companion for a tedious railway journey. Several of the characters are quite impossible and the scenes depicted and the conversations recorded most improbable. The romance is sanguinary and the tragedy comic. There is no motive and no object. The book is as stimulating as a column of a murder case presented by the yellow press. We trust Dr. Dabbs will not wander further into this unwholesome land of medico-legal travesty. The present shilling shocker is quite unworthy the author of such a clean, dainty and altogether charming prose-poem as "Before Good-Night." Dr. Dabbs will do well to leave the evil-smelling deeds and contents of the pawnshop and revel as of old in the fresh breezes of the open country he knows and loves so well.

The Hunterian Society.

A MEETING of this society will be held at the London Institution, Finsbury Circus, E.C., to-day, when a discussion upon Influenza will be opened by Professor T. C. Allbutt, F.R.S. The discussion will be continued on April 26th. Among those who have promised to take part are Dr. H. Franklin Parsons, Dr. F. J. Smith, Dr. I. Burney Yeo, and Dr. T. Glover Lyon.

(a) "The Surgical Treatment of Bright's Disease." By George M. Edebohls, A.M., M.D., LL.D., Professor of the Diseases of Women in the New York Post-Graduate Medical School and Hospital. New York: Frank F. Liscichl. 1904.

(c) "Mr. Watch, Pawnbroker." By George H. R. Dabbs, M.D. Pp. 133. London: Partridge and Cooper. 1905. Price 1s.

Obituary.

**SAMUEL STEELE PERKINS, M.D. ST. AND.,
M.R.C.S.ENG., L.S.A.**

At Exeter, on March 7th, Dr. Samuel Steele Perkins died at the advanced age of 86 years. He was M.R.C.S. in 1840, L.S.A. in 1842, and M.D. St. And., in 1872.

RICHARD O'LEARY, L.S.A., M.R.C.S. ENG.

We regret to record the death of Dr. Richard O'Leary, one of the oldest medical practitioners in Liverpool. Of late only, owing to a fatal malady, he had to relinquish work, the practice being carried on by his son, Dr. Arthur J. O'Leary. The deceased took great interest in all political and sanitary matters. For the past forty years he practised in Brownlow Street, having been previously in Bradford and Oxford. Dr. O'Leary was in his 78th year, but had not retired. He leaves a widow, one son, and two daughters.

BASIL ALEXANDER SPENCE, M.B., CH.B. EDIN.

News was received at Burntisland last week of the death, at Rio Janeiro, of Dr. Basil A. Spence, eldest son of Dr. Spence, Burntisland, Scotland. Dr. Basil, Spence who was only 27 years of age, after graduating at Edinburgh, four years ago, was two years in Bradford Hospital. His devotion to duty somewhat impaired his health, and he sought engagement as surgeon in the Atlantic and Pacific lines. He was on his second voyage in the Pacific Company's steamer *Oravia*, and died at Rio of phthisis. Much sympathy is felt for Dr. Spence in the bereavement, and at the sudden and early termination of a promising career.

**JOHN FRANCIS SCOTT FOWLER, M.B., C.M.
ABERD.**

News has been received of the death on March 3rd, at Georgetown, British Guiana, of Dr. J. F. S. Fowler, surgeon at the Colonial Hospital there. He was born in St. Helena 40 years ago, and received his professional training at the University of Aberdeen, where he graduated M.B., C.M. in 1885. He married a daughter of Mr. David Sinclair, of Aultens.

DR. MAURICE EVANS, J.P., OF CAERPHILLY.

DR. MAURICE GRIFFITH EVANS, whose death at the age of 73 took place at his residence on Thursday last, was the son of a former vicar of Llangolman, Pembroke-shire. He was a student of Guy's Hospital, and obtained the M.D. degree, Aberdeen, in 1859. He commenced practice at Narberth some forty-five years ago. During his stay at Narberth he took a leading part in all public and philanthropic movements, and was always to the fore in advocating all things appertaining to the well-being of the people. He subsequently removed to Cardiff, where he created a large and lucrative practice, and for two years held the post of President of the Cardiff Medical Society. About ten or twelve years ago he retired from the profession which he had adorned and went to live at Caerphilly, where he became a most active and respected magistrate. He had been in failing health for some time.

New Inventions and Appliances.

**THE PREVENTION OF CARBOLIC ACID
POISONING.**

THE injuries and deaths due to the ignorant and negligent employment of the long popular and widely used disinfectant carbolic acid show no sign of abatement. Any method whereby these constantly recurring disasters may be prevented or even lessened deserves careful consideration. Messrs. Thomas Christy and Co., of Old Swan Lane, London, have sent us a specimen of a new and patented locked bottle. The attachment is fitted to a twelve ounce blue bottle of carbolic acid, being firmly fixed in a groove on the neck. A metal cap covered by rubber serves as a stopper and on the upper surface of this a hinged

metal cap is locked, the key being attached by a short metal chain. Although taking some little time to adjust and lock, the invention is certainly one which, provided it is rightly employed, will go far to diminish the heavy toll of deaths from carbolic acid. We are of opinion that the value of the attachment might be increased by making the lock automatic. In its present form there is the danger that slipshod humanity may neglect to put the key in the slot and make the turn which means safety. The lock must be firm and fast which frustrates human frailty.

Medical News.

Irish Medical Schools' and Graduates' Association.

THE annual festival dinner of the above association was held on March 18th, 1905, in the Grand Hall of the Hotel Cecil, the President, Sir William Whitla, in the Chair. Covers were laid for upwards of 260, and among those assembled were Mr. John Tweedy, President of the Royal College of Surgeons of England; Mr. Arthur Chance, President of the Royal College of Surgeons of Ireland; Inspector-General W. H. Lloyd, R.N., Director-General A. H. Keogh, C.B., Mr. Thomas Lough, M.P., and Dr. P. S. Abraham, Vice-President of the Association. After the loyal toasts had been duly honoured, the Arnott Memorial Medal was presented to Captain Thomas Campbell Mackenzie, D.S.O., R.A.M.C., who was introduced by Dr. J. H. Swanton, chairman of Council. This medal was founded by Mr. David T. Arnott, in 1900, in memory of his father, the late Sir John Arnott, Bart., to be awarded to the medical graduate of an Irish University or a diplomate of an Irish Corporation who shall have performed (a) an act of heroism or distinguished service in the discharge of medical duties, either in civil life or in the naval or military services, at home, upon the high seas, or abroad; (b) any achievement in medicine or surgery, or medical research. The medal has been awarded four times already. The circumstances of Captain Mackenzie's heroic act, which consisted in rescuing life at sea under conditions of great peril, having been briefly narrated, the medal was handed to the gallant young officer by Lady Whitla, amidst loud applause, the whole company joining in singing "For he's a jolly good fellow." The toast of "Our Defenders" was proposed by Dr. T. G. Fitzgerald, who included the whole bulk of the medical profession among those who strove for the protection and welfare of the country. Inspector-General Lloyd responded on behalf of the Senior Service, and Director-General Keogh, in replying for the Army, said that he had had the honour to be the chief of the Irish Regiment with which Captain Mackenzie was connected. This was the first occasion, however, in which the Arnott Medal had been awarded for saving life at sea. Mr. Arthur Chance offered a cordial welcome to "The Guests," and in doing so he made allusion to the restrictions attached to certain hospital appointments in England. Genius was essentially international, and it could never be limited by mere geographical considerations. Mr. Thomas Lough, M.P., in replying to the toast, referred in sympathetic terms to the condition of medical practice in Ireland under the Poor-law administration. For the last ten years he had closely identified himself with any party which set itself to right the wrong. He, in company with the other guests, greatly appreciated the unstinted flow of hospitality which marked the evening's celebration. Mr. John Tweedy (in the absence of Mr. T. A. Campbell, K.C., M.P.), proposed the toast of "Ourselves," in a few well-chosen words, to which the President suitably replied. An efficient musical programme was provided, and a good number of ladies graced the Association with their presence.

Trinity College, Dublin.

THE following candidates passed the Final in medicine at Hilary Term, 1905:—Eva J. Jelllett, William J. Powell, Charles R. M. Morris, Robert Magill, William Hassard, William R. Galwey, William F. Samuels, John Murdoch, Henry E. M'Cready, and Cecil Scaife.

The Chemists' Exhibition.

THE eleventh annual gathering of manufacturing chemists, and of import and export firms supplying the retail chemist with the multifarious "accessories" of his business, amply proved, if proof were necessary, that it was a much needed institution and has come to stay. The idea originated with, and the organisation is still kept going by, the proprietors of the *British and Colonial Druggist*, one of the journals devoted to the interests of the trade, and the exhibition held during last week was probably more complete and more popular than any previous one, the interior of the Royal Italian Opera House, Covent Garden, lending itself to a more extensive display of wares and decorative attractions than buildings used for the purpose on previous occasions. An exhibition of this character must naturally become of increasing usefulness as it brings into personal contact two forces—the manufacturer and the retailer—in both of which the medical profession is directly or indirectly interested. All that is newest in pharmacy in its broadest ramifications can here be seen and compared, and the chemist from remote parts of the kingdom has the further temptation to visit London placed within his reach by special rebates of fares, arranged by the promoters of the undertaking with the railway companies. It is not our purpose to describe in detail an exhibition arranged for chemists; this has been already fully done by their recognised organs; suffice it for us to chronicle a distinct success and to congratulate all concerned in bringing about this result.

The Registration of Nurses under the Companies Act.

DURING the past week, Mr. T. M. Healy, M.P., asked the President of the Board of Trade in Parliament, if the Board had received an application for a licence to incorporate a society for the higher education of nurses, from gentlemen unconnected with medicine or surgery; and, if so, did the Board still adhere to the view expressed in a letter written by the Board on August 6th, 1891, to Dr. Bedford Fenwick, in which it was stated that it appeared to the Board of Trade that they were not competent to determine the very important question connected with the establishment of a register of nurses, which should be settled before the register can be effectively established; and that, under the circumstances, the Board of Trade were unable to grant the desired licence to the Royal British Nurses' Association; and that the Board were convinced that full inquiry (by competent authorities) into all the facts and circumstances of the case, and into the objections that had been raised, should precede any further steps on the part of the Government; and whether, if any change had since taken place in the policy of the Board in dealing with the question of the registration of nurses, he could indicate the nature and grounds of such change.

Mr. G. Balfour replied to the effect that an application had been received by the Board of Trade for a licence to incorporate, under Section XXIII. of the Companies Act, 1867, without the word "limited," a society for the higher education of nurses. The proposed memorandum and articles of association, which had been submitted to the Board of Trade, were subscribed by seven gentlemen, none of whom were members of the medical or surgical profession—one of whom, however, was chairman of the London Hospital. The Board of Trade proposed to hear both the applicants and the objectors to the grant of a licence, and till after such hearing did not propose to issue any decision as to policy or otherwise.

French Congress of Climatology and Hygiene.

THE Congress will hold its assembly in Arcachon, Pau, during Easter week, April 24th to 29th, 1905. The organisation committee having its headquarters in Arcachon, and from whence will leave the various excursions already arranged: Visit to the forest that provides Arcachon with its protective belt; to the shores of the bay that produce the exceptional climatic conditions of this station; and also to the ocean shores where the Atlantic climate reigns in all its rugged splendour. The following are the latest official arrangements for this Congress, to which we briefly

referred in a recent issue:—Friday, April 28th: Departure for Pau in the evening by special train. Saturday, April 29th: Work of inspection at Pau, discussion of two reports relative to this station, reading of the latest communications, and closing *seance*; fetes organised by the Pau municipality. Sunday, April 30th, and Monday, May 1st: Excursions to Biarritz, Hendaye (Sanatorium), Fontarabia, and return if so wished by Bayonne and Cambo. Reduction of 50 per cent. granted by all the French railways to members of the medical profession, &c. (subscription, 20 francs), and to their wives and children registered as associate members (subscription, 10 francs). The last date for inscription is April 5th. After this date the committee decline all responsibility of forwarding in time the necessary forms for obtaining reduction of railway fares or the designation of hotel accommodation. Members of the Congress will receive all information relating to the organisation, discussions, and excursions as soon as they are enrolled. Titles of communications should be addressed to the General Secretary, accompanied by a clear *resume* in the form of a summary. Applications for membership must be addressed with the subscription to the General Treasurer, Dr. Déchamp, Arcachon; other correspondence relative to railway fares, tickets, hotel accommodation, &c., address General Secretary, Arcachon.

The Gold Medal of the R.H.S. for a Medical Officer of the R.A.M.C.

THE Stanhope Gold Medal, the highest award given by the Royal Humane Society, has been given to an Irish medical man, Captain T. C. Mackenzie, D.S.O., R.A.M.C. The action for which this award was given took place under the following circumstances:—On September 22nd, the steamship *Saghalian*, on her homeward voyage, was in the Ionian Sea, when a youth fell overboard. Captain Mackenzie, who was being invalidated home after a severe attack of typhoid, at once jumped after him. A lifebelt was thrown, which he secured, and with it reached the youth, who was in difficulty. A second buoy now drifted near, and to this he tied the lad, and then, lashing both buoys together, calmly awaited rescue. Owing to the choppy sea and the speed of the vessel they had been lost sight of, and it was not till forty minutes after that they were again sighted, and picked up by a boat. Captain Mackenzie was formerly a student of the Royal College of Surgeons in Ireland, and of the Royal City of Dublin Hospital, both of which institutions we congratulate on the gallantry of their pupil.

Hospital Economies.

MR. EDGAR SPEYER, a member of the General Council of King Edward's Hospital Fund, has, with the approval of the Prince of Wales, president of the fund, offered a prize of £100 and a silver cup for the best essay on the subject of "The Economical Management of an Efficient Voluntary Hospital." The Prince of Wales has consented to present the prize to the successful competitor. The competition is limited to the paid secretaries and assistant secretaries of voluntary hospitals in the United Kingdom and Ireland. Particulars and conditions may be obtained on application to the honorary secretaries of King Edward's Hospital Fund, 81, Cheapside, London.

Society of Apothecaries of London.

THE following candidates, having passed the necessary examinations, have been granted the diploma of the society (L.S.A.), entitling them to practise medicine, surgery, and midwifery:—J. Borle, J. M. S. Duncan, J. E. Jones, and A. Rogers.

DR. H. FRANKLIN PARSONS, Assistant Medical Officer to the Local Government Board, has been placed on the Inter-Departmental Committee, having for its object to inquire into and report on the health, food, and methods of relief of children in public elementary schools.

MR. E. K. MUSPRATT, President of Council of the University of Liverpool, has offered the large sum of £10,500 to provide for an extension of the chemical laboratories and its equipment, which offer has been gratefully accepted.

Notices to Correspondents, Short Letters, &c.

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

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 re-forwarding 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.

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.

TOO LITERAL.

Doctor: "Well, Mike, did you take the box of pills I sent you?"
—Mike: "I did that so," but I don't feel any better. I expect the id haven't come off yet!"

A. M. F. (Mentone).—The Crown Agent for the Colony would be the proper official to whom to apply.

R. W. P.—We must request our correspondent to curtail his remarks as well as his personalities. In its present form we cannot publish his communication.

F. C. G. (Manchester).—The good offices of a mutual friend might with advantage be sought in order to adjust the differences.

QUEERNS.—The ethical law is precise upon the matter; our correspondent should, therefore, withdraw his contention.

DR. H. (Newcastle-on-Tyne).—The case would come under the Workmen's Compensation Act.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MARCH 22nd.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus, E.C.).—8.30 p.m. Discussion upon Influenza (opened by Prof. Albutt). Contributions by Dr. F. Parsons: Causes of Influenza. The Discussion will be open to all members of the medical profession.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. J. Berry: Clinique. (Surgical.) 5.15 p.m. Dr. J. E. Squire: Murmurs in the Chest not due to Heart Disease.

CENTRAL LONDON THROAT AND EAR HOSPITAL (Gray's Inn Road, W.C.).—5 p.m. Demonstration:—Mr. S. Low: Oro- and Laryngo Pharynx.

THURSDAY, MARCH 23rd.

CHILDHOOD SOCIETY AND THE BRITISH CHILD STUDY ASSOCIATION (Parkes Museum, Margaret Street, W.).—8 p.m. Lecture:—Miss Lawrence: Method of Training Froebelian Teachers. (Arranged by the Childhood Society.)

ROYAL COLLEGE OF PHYSICIANS OF LONDON (Pall Mall East).—5 p.m. Dr. W. C. Bowman: Some Considerations on the Nature of Diabetes Mellitus. (Goulstonian Lecture.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Mr. J. Sherran: Some Surgical Observations on Referred and Reflected Pain.

FRIDAY, MARCH 24th.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8.30 p.m. Papers: Mr. D. Drew: Three Cases of Stenosis of the Ureter.—Dr. N. Dalton and Mr. A. D. Reid: Examination of the Stomach by Aid of the X-rays and a Tube filled with Substrate of Bismuth.—Mr. A. E. Barker: Two Cases illustrating the Condition of the Small Intestine some years after Extensive Enterectomies.—Sir Dyce Duckworth: A Case of Streptococcal Pachymeningitis.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Dr. H. Tilley: Clinique. (Throat.)

MEDICAL CONFERENCE ON THE TEACHING OF HYGIENE AND TEMPERANCE (Examination Hall, Victoria Embankment, W.C.).—5 p.m. Addresses by Sir Victor Horsley, Dr. E. Jones, Sir Thomas Barlow, and Mr. McAdam Eccles.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Lecture-Demonstration:—Mr. de Prenderville: Anesthetics.

SATURDAY, MARCH 25th.

THE ROYAL SANITARY INSTITUTION (Parkes Museum, Margaret Street, W.). 11.30 a.m. Discussion on Municipal Milk Depots and Milk Sterilisation (opened by Dr. G. F. McCleary). Dr. J. Groves, Prof. H. E. Kenwood, Dr. H. C. Pattin, Dr. H. M. Richards, Dr. J. Robertson, Dr. E. C. Seaton, Dr. E. Walford, and Dr. W. G. Willoughby will take part in the discussion. In the afternoon visits will be made to the Battersea Municipal Milk Depot, and to the Disinfecting Station, Public Mortuary, Coroner's Court and Shelter.

MONDAY, MARCH 27th.

ODONTOLOGICAL SOCIETY OF GREAT BRITAIN (20 Hanover Square, W.).—8 p.m. Casual Communication will be given by Mr. Charles A. Clarke, L.D.S. (Edin.), on "A Sterilisable Bar-Box." A Paper will be read by Mr. J. Thornton Carter, L.D.S. (Eng.), on "The Evolution of the Vertebrate Skull, with special reference to the Development and Suspension of the Jaws."

TUESDAY, MARCH 28th.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Mr. de Prenderville: Lecture-Demonstration on Anesthetics.

Vacancies.

Assistant Medical Officer for Private Asylum.—Salary £100 per annum, with board.—Applications to Medical Superintendent, The Brook Villa, Liverpool, E.

Ayr District Asylum.—Junior Medical Officer. Salary £120 per annum, with board, furnished apartments, attendance, and washing. Applications to the Medical Superintendent.

Carmarthenshire Infirmary.—Resident Medical Officer. Salary £100 per annum, with furnished apartments, board, attendance, fire, gas, and washing, &c. Applications to Howell Howell, Secretary.

Glasgow District Asylum, Woodilee, Leaside.—Junior Assistant Medical Officer. Salary £125 per annum, with board, lodging, washing, &c.—Applications to the Medical Superintendent.

Cameron Hospital, West Hartlepool.—House Surgeon. Salary £100 per annum, with board, rooms, and washing. Applications to J. G. Taylor, Secretary.

Gravesend Hospital.—House Surgeon. Salary £100 per annum, with board and residence. Applications to F. H. Stevens, Hon. Secretary, 146 Milton Road, Gravesend.

Western-super-Mare Hospital.—House Surgeon. Salary £100 per annum, with board and residence in the hospital. Applications to the Honorary Secretary.

Birmingham and Midland Eye Hospital.—Resident Surgical Officer. Salary £100 per annum. Applications to the Chairman of the Medical Board.

Somerset and Bath Asylum, Wells.—Senior Assistant Medical Officer. Salary £175 per annum, with board, lodging, washing, and attendance. Applications to the Medical Superintendent.

Somerset and Bath Asylum, Wells.—Second Assistant Medical Officer. Salary £150 per annum, with board, lodging, washing and attendance. Applications to the Medical Superintendent.

East London Hospital for Children and Dispensary for Women, Shadwell, E.—Secretary. Salary £300 per annum. Applications to Thomas Hayes, Secretary.

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

Bubery Hill Asylum, Birmingham.—Two Junior Assistant Medical Officers. Salary £150 per annum, with board, lodging, and washing. Applications to the Medical Superintendent.

London County Asylum, Cane Hill, Coulsdon, Surrey.—Junior Assistant Medical Officer. Salary £150 per annum, with board, furnished apartments, and washing. Applications to H. F. Keene, Acting Clerk to the Asylums Committee, 6 Waterloo Place, S.W.

Royal Orthopaedic Hospital, 55 Boilever Street, W.—House Surgeon and Registrar. Salary £200 per annum, with rooms, but without board.—Applications to Tate S. Mansford, Secretary.

County of London.—Asylums Committee Epileptic Colony, Ewell.—Assistant Medical Officer. Salary £200 per annum, with board, furnished apartments, and washing. Applications to H. F. Keene, Acting Clerk, Asylums Committee Offices, 6 Waterloo Place, S.W.

Appointments.

CONDON, R. F., L.R.C.P. & S.I., Certifying Surgeon under the Factory and Workshop Act for the Broadford District of the county of Limerick.

COUPLAND, J. A., M.B. Lond., Resident Surgical Officer at the Leas General Infirmary.

DAWE, F. SHERWILL, M.D., B.Sc. Lond., Casualty Physician to St. Mary's Hospital, London.

DICK, M. I., M.B., B.S. Glasg., Certifying Surgeon under the Factory and Workshop Act for the Staveley District of the county of Westmorland.

FELDMAN, M. M.B.C.S., L.R.O.P., L.C.C. Lecturer in Midwifery to Midwives.

Births.

EVANS.—On March 16th, at 2 Upper Wimpole Street, London, W. the wife of Willmott Evans, M.D., M.B.C.S., of a daughter.

GLASIER.—On March 15th, at Mildenhall, Suffolk, the wife of Howard Glasier, M.A., M.B. Cantab., F.R.C.S., of a son.

Deaths.

COOPER.—On March 16th, at Malaga, S. Spain, John Jehu Cooper, third son of the late Dr. Peter Cooper, of Appleby, Leicestershire, aged 55 years.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXX.

WEDNESDAY, MARCH 29, 1905.

No. 13.

Original Communications.

THE TYMPANUM AN ABSCESS CAVITY.

A CLINICAL LECTURE DELIVERED AT THE POST-GRADUATE COLLEGE AND POLYCLINIC, LONDON.

By MAYO COLLIER, M.S.Lond., F.R.C.S.Eng.,
Senior Surgeon to the North-West London Hospital, &c.

GENTLEMEN,—The patient before you is 15½ years of age, and, as you may see, is somewhere about 6 feet 1½ inch, and well made in proportion. He is a very fine specimen of the genus homo, and just such a one as would do justice to the King's uniform in one of the Household regiments. All these natural advantages, I regret to say, are sadly discounted by the fact that he has an abscess, and a discharge that has persisted now for over four years. The abscess in his case is situated within the tympanum. The discharge is flowing outwards from the auditory canal. He has spent the last four years of his life, and his parents a considerable sum of money, in trying to get rid of this discharge. His education has been neglected, his prospects impaired, his future discounted, and all through a little collection of pus in a little cavity whose dimensions would hardly exceed a large pea. Such an abscess in many other parts of the body might be treated with indifference, and its presence neglected. But when in the ear, as in this case, it may defy the close attention of several medical men for a number of years.

In what way, then, does an abscess of the tympanum differ from an abscess in any other part of the body? Is there anything inherently difficult in the constitution and treatment of an abscess of the ear to prevent its early resolution? Why should an abscess of the tympanic cavity continue regardless of treatment for years, when an abscess, say, on the buttock, might discharge itself and close in a fortnight?

Are the ordinary principles of surgical treatment not applicable to a collection of pus in the tympanic cavity? If natural resolution is so difficult, in what way does an abscess of the tympanum ultimately terminate? Without in any way encroaching on the functions of the aurist, I think we can with much profit to ourselves examine each and all of these questions this afternoon. Every medical man who practises his profession, be he surgeon, physician, or specialist in any department, should certainly possess sufficient know-

ledge to diagnose and treat an abscess of the tympanic cavity.

It is of little avail to send a patient with a chronic foul discharge from the ear to a specialist, after years of valuable time have been wasted by temporising, syringing and piously hoping that Nature, in the exuberance of her tolerance, will do for you what you have no right to expect of her. It amounts to criminal folly for anyone holding a licence to practise medicine to lead a patient with a discharge from his ear to hope that he has the slightest chance of "growing out of his trouble." Such statements are, and can only be made from sheer want of knowledge of the main facts—the anatomy, pathology and treatment of a tympanic abscess.

Without hesitation you will agree with me that if there is one department of medicine that receives the least attention or notice from the bulk of students and medical men it is the ear. I know from experience, as a teacher of anatomy for many years, that not one student in fifty would get up the minute facts of the tympanic cavity, unless he were going in for the Fellowship or a university degree. An aural department, even at our large hospitals, is a modern institution, and I can remember that even in my time it was found difficult to obtain clerks to assist in the aural department of my hospital. An aural clerkship was always the least coveted of all the house appointments. This state of things was more or less due to the fact that then the diseases of the ear were little understood, and their study confined to the practice of quite a few pioneers in this particular department of medicine.

Within the last twenty-five years all this has altered. There is not a hole or cranny or crevice of the human body that is not now besieged by an army of ardent explorers, and much useful and essential knowledge has been gained that should be the common property of us all. A want of knowledge of the ordinary facts connected with the causation, pathology and treatment of an abscess or discharge from the ear may involve the innocent and confiding patient in the most serious consequences, even to the loss of his life. Every surgeon with hospital experience knows too well the appalling consequences of a neglected aural discharge. A temporo-sphenoidal or cerebellar abscess, a septic thrombus of the lateral sinus with septic infarcts in lung and spleen, are a few of the troubles that may follow an aural discharge.

An abscess may be defined as a collection of pus in any part of the body, but abscesses not only differ in regard to their contents, but in regard to

their sacs or walls also ; the majority of abscesses have soft, elastic walls that shrink and collapse on the discharge of their contents ; others, such as collections of pus in cavities with bony or rigid walls, cannot collapse on the discharge of their contents. And here lies all the difference, and all the difficulty in treating a collection of pus in the pleura or any of the accessory cavities of the nose. In the one the cavity obliterates itself, and so cures the abscess ; in the latter the abscess wall is rigid and cannot collapse or diminish, and the pyogenic membrane remains to secrete pus and to continue the discharge. The term "empyema" is more often used for collections of pus in cavities with rigid or bony walls, and I think the same term would be more applicable to collections of pus in the tympanum. An empyema of the tympanum would be a more appropriate description than an abscess ; empyema being an abscess under certain conditions. It is becoming apparent, then, that an abscess or empyema of the tympanum does differ from a collection of pus in the soft tissues, and part of the difficulty in treating such a collection is on this account.

The difficulty of treating an empyema of the tympanum is greatly enhanced by the nature of that cavity, its position and surroundings. If you will turn to this diagram or to this base of the skull, you will see that the tympanum is situated in the very heart of the temporal bone. It is a considerable distance from the surface, and is entirely inaccessible except by way of the external auditory canal and tympanic membrane. I venture to state that there is no more interesting spot in the whole human body than the tympanum. It is surrounded on all sides by the most vital structures, and in some cases it is separated from them by a hair's breadth. An abscess in the tympanic cavity is more potent for harm than an abscess in any other part of the body. Besides destroying the functions of hearing, it may cause death in a dozen different ways.

I think this interesting little cavity is worthy of your attention. The cavity may be described as an oblique section of a cylinder, some half-inch in diameter, and about one-twelfth to one-sixteenth of an inch across at its narrowest part, the centre or umbilicus of the tympanic membrane. The upper part of the tympanic cavity above the tympanic membrane is the attic. This is separated from the brain cavity by a thin plate of bone, the tegmen tympani ; caries of this plate of bone or extension through it of the inflammatory process in chronic otitis media may lead to abscess of the temporo-sphenoidal or occipital lobes, extradural abscess, or meningitis. The floor is equally important, and is separated by a thin plate of bone from the internal jugular vein.

Caries or otitis media may cause fatal hæmorrhage or septic thrombosis, embolism and metastatic abscesses. The anterior wall is quite narrow, presents the Eustachian tube, the canal for the tendon of the tensor tympani, and below these is separated by a thin plate of bone from the internal carotid artery. Here, again, caries with otitis media may cause ulceration into the artery with fatal results.

The posterior wall presents at its upper part a considerable opening which leads into the mastoid antrum, another important recess such as the attic was found to be. Below the opening near the inner wall is the pyramid with the stapedius tendon passing from it, and external to the pyramid the

chorda tympani nerve emerges to pass forwards to the glaserian fissure.

The mastoid antrum embraces a small cavity not much larger than a pea, but one of considerable importance, because it is here that collections of pus are so frequently found in middle-ear disease. The roof of this cavity is separated from the brain cavity by a thin plate of bone, the tegmen antri, and the same consequences may follow its destruction as in the case of the tegmen tympani. Moreover, it is perforated by veins that pass directly into the superior petrosal sinus. The floor of the antrum is perforated by communications with the mastoid cells. The anterior wall separates the mastoid antrum from the external auditory canal. Through this wall a mastoid abscess may be evacuated by way of the external auditory meatus. The posterior wall of the antrum is a bony lamina of variable thickness, separating the antrum from the lateral sinus. Through this plate of bone veins pass from the middle ear and mastoid antrum to the lateral sinus. Septic matter may thus easily reach the lateral sinus and cause septic thrombosis and embolism.

The inner wall of the antrum is at some depth from the surface, and varies from three-quarters of an inch in adults to a quarter of an inch in children. On it lies the eminence of the canal for the facial nerve, which may be easily wounded or divided in opening the mastoid antrum. The outer wall of the antrum is formed by the descending plate of the squamous portion of the temporal bone, and is included in what is known as the supra-meatal triangle of MacEwen. The supra-meatal triangle of MacEwen is bounded above by the posterior root of the zygoma. The upper margin of the bony meatus forms the antero-inferior boundary. The posterior boundary is formed by a perpendicular line extending from the most posterior portion of the bony meatus to the posterior root of the zygoma. The surface of this area is usually depressed. Through this triangle the mastoid antrum may be reached with safety if the perforation is directed inwards and somewhat upwards, and forwards or parallel with the external auditory canal. The mastoid cells are continuous with the mastoid antrum. They are separated posteriorly by a thin plate of bone from the sigmoid or lateral sinus, through which veins pass from these cells to the sinus, forming a ready means of infection and septic thrombosis.

We thus see that in every direction we are surrounded by complications and dangers, and, moreover, we can gather that a most accurate and minute knowledge of the anatomy of these parts is essential to success in operating in this region. A neglect to study the anatomy of the middle ear is the primary cause of the neglect to study its commoner diseases.

The next question we set ourselves to inquire into was this : Is there anything inherently difficult in the constitution and treatment of an abscess of the ear to prevent its early resolution ? I would say undoubtedly yes. The tympanic cavity is one of the accessory cavities of the nose. It is developed from the common nose and mouth cavity as provided by the first branchial cleft. The ossicles are developed from Meckel's cartilage, and are properly outside the tympanic cavity in the same way as the liver is outside the abdominal cavity. The tympanum normally is in direct communication with the naso-pharynx, by means of the Eustachian tube. This tube happens to

be very narrow at about its middle, and its coverings are easily swollen by catarrh or differences in pressure, and so its lumen is not unfrequently obstructed. The Eustachian tube is the natural ventilator and drain of the tympanic cavity. Here we have a fact that explains much. The natural ventilator and drain of the tympanum may become easily obstructed by congestion, catarrh, direct pressure, or differences in air tension, and other causes. Here is the *fons et origo mali*. Any affection of the nose, be it catarrh or what not, is liable to affect the tympanum in one way or another.

In treating an abscess of the ear, to ensure success you must treat also the nose and post-nasal space. You must restore the parts to the *status quo ante*, or no success will attend your endeavours. This boy was treated for two or three years for his tympanic abscess, and the presence of a mass of adenoids in the naso-pharynx as large as a walnut, with almost complete nasal obstruction, was ignored. We removed the adenoids, and ventilated the nose freely, but we were locking the stable-door when the horse was gone. We did the right thing, but too late. From the duration of the discharges, and the offensive odour, I fear there is now caries, and nothing but a radical operation would cure this case.

These troubles usually commence by an extension of an influenzal or other catarrh into the tympanic cavity from the throat. The catarrhal process invades the tympanic cavity, and causes congestion of its lining membrane and outpouring of fluid. The same process closes the lumen of the Eustachian tube. The capacity of the tympanum is diminished by reason of the absorption of its air contents, whilst *pro rata* the congestion of the lining membrane and the tension increases. This condition of things is the starting-point of most of these chronic discharges. An example of such you now see before you. This condition of things, if dealt with promptly and efficiently, by the most simple means, would in most cases save the patient from a long list of troubles that may follow a neglected discharge from the ear. Now, in assuring you that not one of you could help becoming efficient in the early treatment of an abscess of the ear in the space of time that I am talking to you, we will first proceed to examine the last question we put to ourselves.

Are the ordinary principles of surgery not applicable to an abscess of the ear? A free incision and drainage would be all that is required in most cases of abscess to effect a cure; but in the ear this is not practicable. Nature usually makes her own incision, and the pus flows outwards through a hole in the *membrana tympani*. I am not for a moment suggesting that you should incise the membrane, unless you are an expert in handling the various instruments and lights requisite.

I do not for a moment suggest that you should always examine the ear to make your diagnosis. The fact of deafness and discharge are enough for you. Your diagnosis is made for you. A discharge from the ear means an abscess of the tympanum in ninety-nine cases out of one hundred. The ordinary principles of surgery must be applied here. You must drain the abscess. True, you cannot put a tube into the cavity, but you can do something quite as efficient, or more so; you can blow out the contents of the cavity once or twice or three times daily with the simple use of the

Politzer bag, and wash away the discharge from the auditory canal by the help of a syringe and a little antiseptic lotion. If you will do this you will succeed in a majority of cases in curing your patient and saving him from a chronic discharge and more serious consequences.

It is for first aid in ear affections that I am pleading to-day. First aid in ear affections is as essential as first aid in war or accidents. It gives you time to consider and examine into the condition of the nose and naso-pharynx, and formulate a more radical and definite line of treatment. In the treatment of these cases a spray, of menthol dissolved in parolene, and the addition of a few grains of cocaine, will greatly assist the use of the Politzer bag.

The last question we have to examine has been partly answered. The result or ending of a discharge from the ear may be in one of several directions. It may continue with intermissions till the patient dies of some other trouble. It may dry up and cease spontaneously—this is rare. Or it may cause the death of the patient by cerebral abscess, meningitis or pyæmia. With the operative procedure for the relief of these complications you will not to-day be troubled.

SOME CASES OF JOINT EXCISION. (a)

By DENIS KENNEDY, F.R.C.S.I.,

Surgeon to Jervis Street Hospital, Dublin; Surgeon, Children's Hospital, Dublin.

THE havoc that is wrought by tuberculous disease in joints, the numbers of cases that crop up daily for treatment, and the inefficiency frequently of such treatment is my excuse for bringing briefly under your notice the following cases:—

Case I.—W. G., æt. 32, came to me about four years ago with the following history: About six years previously he sprained his knee breaking a stick across it. Swelling and pain supervening, he consulted a bone doctor, who pretended to reduce a dislocation of the knee-cap. The patient's subsequent history was simply one of tuberculous knee-joint, going from bad to worse. He was constantly under the care of his local doctor, besides being treated in a couple of Dublin hospitals from time to time, the usual routine treatment being apparently followed. Counter-irritation, fixation of the joint and opening of abscesses according as they formed. As time went on his condition, both locally and generally, seemed to have got steadily worse. When I saw him he was in a pitiable state. He hobbled about on a pair of crutches, the knee-joint was fixed at right angles, greatly enlarged, and many sinuses were present. He had a bad cough, was very emaciated, suffered from night sweats, and on examination, evidence of a large cavity in the right lung was easily obtained. His mental condition was bordering on despair. At his urgent request I decided to undertake an excision of the knee, permission being readily given for amputation if necessary. I carried out the operation in Miss Mason's private hospital in Baggot Street, assisted by Surgeon Tobin and Dr. Dargan, who gave the anæsthetic. The bones were extensively diseased as well as every part in the neighbourhood of the joint. The great difficulty of the operation was to bring the

(a) Paper read at the Meeting of the Academy of Medicine, Surgical Section, February 21th, 1906.

leg straight even after a section of the hamstring tendons. I used Tobin's calipers and dowel to fix the bones together, and as a proof of their efficiency I may mention that just before the patient was brought back to bed he became violent, and actually rolled on to the floor from the operating table; nevertheless, the bones never moved. He made an uninterrupted recovery. In less than six weeks he was up and about, and before three months I showed him at the Academy, then walking without a stick. I found massage of the greatest possible benefit in restoring the wasted muscle of the limb, and consequently enabling the patient to get about much earlier than otherwise. He is now in perfect health, the lung trouble having completely disappeared, and he is able to work all day without the least difficulty on his farm. The points of interest that appeal to me in this case are: (1) the



TOBIN'S CALIPERS AND DOWEL IN POSITION FOR FIXING THE BONES TOGETHER AFTER EXCISION OF THE KNEE.

absolute failure of palliative treatment, though persistently and carefully carried out; (2) his rapid and complete recovery after excision; (3) the fact that in spite of his lung trouble the administration of ether did not apparently do him the least harm; (4) his lung seemed to improve once the source of infection at his knee-joint was removed. The condition of the knee-joint, being riddled with sinuses, and in a state of ankylosis at right angles for a long period, seemed to contra-indicate excision, while his general condition seemed a bar to any extensive operation at all. As a matter of fact, he was refused operation in two city hospitals a short time previous to his consulting me. His recovery goes to show that with aseptic surgery results can be obtained which were never dreamt of in pre-aseptic days. I attribute the rapid healing of his wound principally to two causes. (1) The use of Tobin's clamps in flexing the bones together. (2) Thorough douching of the joint during the operation with an aseptic fluid. In all cases of excision of the knee I consider fixation of the bones by either clamps such as these, or by wire suture, as an essential detail. I have employed both means, and by both have got satisfaction. For absolute fixation, no suture equals the clamps. By thus fixing the bones, pain after operation is *nil*, bony union is rapid and complete,

and, above all, subsequent flexion of the limb at the site of the operation does not occur. For proof of rapid union after the calipers I need only call your attention to the case of excision of the knee which Mr. Tobin has exhibited to-night. This patient has now been only three weeks operated on, nevertheless, he is up and about without splint or appliance of any kind whatever.

Case II.—Miss A. R., æt. 15, came to me about three and a half years ago with the following history:—Eighteen months previously, while at a boarding school in the South of Ireland, she wrenched her right shoulder playing at tug of war. Some pain and swelling of the joint followed, and for this she was treated by the medical attendant at the school. She improved for a time, but some pain and stiffening seemed to have remained. About four months subsequently, being at home on her holidays, she also consulted a bone-setter, who pretended to reduce a dislocation of the shoulder-joint, using great violence and causing the patient great pain. Improvement followed for a time and she returned to school. Soon, however, her trouble became much worse, and after a short time she had to leave school on account of the pain and stiffening of the joint. When I saw her, her condition was as follows:—She complained of a constant aching pain in the joint, and any attempt at active or passive movement simply produced torture. The muscles round the joint were wasted, the head of the humerus was enlarged and tender. There was no synovial swelling and not a trace of suppuration. Generally she was anæmic and frail-looking, but no organic disease was present. I sent her to a private ward in Temple Street Hospital, and subsequently carried out an excision of the shoulder. The condition I found was very typical of rarefying osteitis. The head of the bone was almost bare of cartilage, and small cavities were present throughout its entire extent. It was simply honeycombed. There was no pus, nor tuberculous debris nor effusion into the joint. The glenoid cavity was healthy. Her recovery was protracted but complete; and I may mention that she is now undergoing a course of technical training in cookery at Kildare Street School, and her teachers have never yet discovered that there is anything wrong with her arm.

Case III.—Miss K., æt. 27, consulted me about eighteen months ago. Her history was as follows:—Seven years previously she noticed a swelling in her left elbow coming on apparently without cause. Some pain was also present on moving the joint, but she continued to perform ordinary household work. After about two years the trouble became worse. She was advised by a surgeon in Chicago whom she consulted to return to her native air in the South of Ireland. This she did, but her elbow appeared to get gradually more useless to her. She suffered a good deal of pain, especially on movement, and swelling occasionally appeared. She then placed herself about two and a half years ago under the care of an eminent surgeon in Dublin. He seems to have done everything possible in the way of palliative treatment, including puncture, firing and fixation of the joint, and subsequently massage, without apparently the least benefit to the patient. After spending about six months in the country, she consulted me, and when I saw her the following condition was present:—Pain nearly always present in the elbow, but greatly increased on the

slightest attempt at active or passive movement. The arm was nearly fixed in a straight position, and the muscles were flabby and wasted. There was no swelling about the joint, no trace of sinus or suppuration, but the lower end of the humerus seemed enlarged and tender. The diagnosis was by no means clear, but, fortified by my previous experience of the shoulder-joint, I diagnosed a rarefying osteitis of the humerus, and recommended excision. This I carried out in Miss Mason's Home in Baggot Street, and I found exactly the same condition present that I had found in the shoulder-joint of the other case. The cartilages of articulation had practically disappeared, and all the bones—humerus, ulna and radius—were again in this honeycombed condition. There was not a trace of pus anywhere and no synovial swelling. The patient made a rapid and good recovery, and six months ago, when I saw her last, she seemed to be on the high road to having a very useful arm, extensive active and passive motion being easily carried out.

These two cases are interesting to my mind, first, from the fact that extensive bone disease was present in each case without any swelling of the joint and without any suppuration, although the disease had apparently been present for years. What was the nature of the disease? It was certainly not syphilitic, and I am not at all sure that it was tuberculous. I have begun to think lately that the word tuberculous covers an amount of ignorance. Secondly, the cases were difficult to diagnose. In both cases I was much aided in coming to a decision by a skiagram. I should like to have the opinion of others as to the value of skiagraphy in diagnosing bone disease. Just one word as to the operations. In each case I removed only as little bone as was absolutely necessary. With early passive motion there was no danger of bony ankylosis, and the possibility of a frail limb was averted. The less bone that is removed in excisions of the upper extremity, the better will the limb be for the patient.

Case IV.—This case is purely traumatic, and, consequently, different from the others. Molly R., æt. 5, was admitted to Temple Street Hospital two years ago with the following history:—Sixteen months previously she fell on her shoulder, and from that time she had no movement in her shoulder-joint. When I saw her the joint was completely ankylosed, and attempted movement produced pain.

A skiagram showed a fracture of the upper end of the humerus, which I assumed to be epiphyseal separation. I opened her joint and found the following condition:—There was an epiphyseal separation about the line of the surgical neck of the humerus, and, again, the articular head was completely separated from the remainder of the epiphysis, and lying loose in the joint cavity. Some fibrous bands connected the diaphysis with the lower part of the epiphysis. I removed the articular head, freshened up the opposing surfaces of diaphysis and epiphysis and sutured them with wire. The union was perfect and the child has an arm difficult to detect that there is anything wrong with it. She is able to perform every movement perfectly.

The subject of tuberculous joints generally is much too great a one for discussion in a short communication such as this. Just one point as to treatment. The difficulty is to know exactly

when palliative treatment must give way to radical. There is one conviction, however, that is forced upon me the more I see of tuberculous joints, that is, that a tuberculous joint in a child may be cured by palliative means. In an adult anything short of the excision of the joint is practically useless. Lastly, I must pay my tribute to the utility of massage in restoring a limb to usefulness when the muscles have been wasted from prolonged disease and from disuse.

SOME CASES OF PERFORATION OF THE STOMACH AND INTESTINES.

By THOS. SINCLAIR KIRK, M.D., M.Ch.,
Senior Surgeon to the Belfast Children's Hospital; Surgeon
to the Royal Victoria Hospital. (a)

THE cases were sixteen in all, beginning with eleven cases of rupture of the stomach, then three of the small intestine, and two peculiar cases of rupture of dilated stomach. The age and sex of patients, and the number of hours that elapsed before operation in the first eleven, are shown in the following table:—

- 1—F., 24, 3 hours, recovery.
- 2—F., 19, 3 hours, recovery.
- 3—F., 45, 10 hours, recovery.
- 4—M., 33, 2 hours, recovery. (Duodenal ulcer.)
- 5—M., 38, 5 hours, recovery.
- 6—F., 33, 20 hours, death 63 days after operation. Severe mitral disease.
- 7—F., 20, 1½ hour, recovery.
- 8—F., 23, 7 hours, recovery.
- 9—M., 23, 2 hours, recovery.
- 10—M., 42, 4 hours, recovery.
- 11—F., 19, 5 hours, recovery.

Looking over this table, the first thing that struck one, Mr. Kirk said, was the short time that generally elapsed before operation, and to this he attributed the general success of the operations. The one fatal case was probably due to the general condition, and not to the rupture at all. No. 3 came into hospital while he was operating on another case, and so could not be operated on at once, and No. 7 was a servant in a medical colleague's household, who secured immediate attention.

The next cases were three of rupture of the small intestine.

1.—A man who sustained a fall from a hay-stack, causing rupture of the ileum. The case was correctly diagnosed by a medical man who saw him in the field where he fell, and who gave him a large dose of morphia and sent him to hospital. On arrival there the symptoms were entirely masked by the morphia and only reappeared after some time. The case was operated on 28 hours after the accident, but died from general peritonitis.

2.—A man whose small intestine ruptured as the result of a blow from a beam of wood. He was operated on in four hours, and recovered.

3.—A typhoid rupture, operated on three hours after occurrence: recovery.

The last cases were two of rupture of dilated stomach, both moribund when admitted to hospital. No general anaesthesia was possible on account of the state. One, a man, was operated on in seven hours, and the other, a woman, in thirteen

(a) Paper read before the Ulster Medical Society, March 23rd, 1905. For discussion see page 526.

hours; both died, and he attributed death to the fermenting contents of the stomach causing fatal peritonitis.

As regards the general lessons to be learned from these cases, Mr. Kirk put first the importance of early operation, and he believed it quite possible to diagnose these cases very early. In only three cases had he opened the abdomen and found no lesion. In two cases large doses of morphia had been given, and he feared by waiting for its effects to pass off he might fall into his former mistake. In the third case the history pointed so clearly to a rupture that he did not hesitate to operate.

If an early diagnosis was to be made, the early symptoms were of prime importance. First of these he placed the history, the important point being a sudden definite local pain and tenderness. Then when seen the patient was generally in a recumbent position, lying on the back and resenting any general movement. Respiratory movements were restricted, and respiration was of the high thoracic type. The general classical symptoms appeared later, but in his opinion, if one waited for absolute certainty in the diagnosis, the prognosis was absolutely certain, too.

As regards treatment, Mr. Kirk said he did not propose to go into details, but there were three points he would notice. The first was to make the incision at the point where the pain began, which would generally be found over the rupture. The next was to make a good large incision, sufficient to admit the whole hand, and lastly he said he did not wash out, but sponged carefully.

THE TREATMENT OF DIABETES MELLITUS.

By S. A. ARANY, M.D.,
Of Carlsbad.

THE efforts of the last two decades to discover something for the cure of diabetes, if taken individually or collectively into consideration, have not so far enriched materia medica with medicinal agents of much value, and the majority of the authors appear to have had recourse to means which seemingly or actually mitigate the course of the disease. The various preparations of the pancreas recommended and employed by French authorities produce in even very mild cases no appreciable effect, and the malt diastase which was for a time much in vogue with some German physicians proved likewise ineffective, especially when employed as originally recommended in connection with an ordinary diet.

The greater part of the English-speaking profession stick to the opiates, in connection with a more or less generous diet, whereas French practitioners usually prescribe exceedingly large doses of antipyrin with an almost non-restricted dietary. As far as the first drug is concerned, it must be owned that in the early stage of the disease it is apt to limit its progress, and the subjective symptoms are generally overcome, especially if large quantities are being administered; but as a general rule, the constipation which is a usual symptom of the disease gets so much worse that the medication has to be discontinued. Antipyrin acts most efficaciously on the nervous symptoms of the ailment; it has, however, no effect whatever upon the elimination of sugar, and is apt, if taken in large doses and for a protracted period, to cause very serious heart symptoms.

In Germany and in Austria, as well as in the Scandinavian countries and to some extent in the United States, diabetes is mostly treated on balneotherapeutic lines, which have proved effective in many cases. Experience has shown that the alkaline waters, and especially such as the alkaline-saline springs of Carlsbad,

are apt to influence and mitigate the course of diabetes. During my repeated visits to London, I heard it from many a *confre* that the spa treatment may be useful in cases of chronic glycosuria, but cannot influence the course of real diabetes. My own experience has, however, proved the contrary: such a sharp distinction between glycosuria and diabetes cannot be drawn, as both are, in my opinion, one and the same disease; they represent, however, different stages of the same. What is generally called glycosuria is, in my opinion, the early stage of the disease, the principal feature of which is the faulty assimilation of carbohydrates and, as a matter of consequence, the appearance of glucose in the urine. In this stage the urine usually contains a considerable amount of sugar, in some cases varying amounts of albumin, but neither acetone nor diacetic or oxybutyric acids can be traced in it. As soon as these latter products appear in the urine, the disease is to be looked upon as having developed into the secondary stage, or what is wrongly called real or grave diabetes. In the secondary stage in which, besides carbohydrates, albuminous matter and tissue are drawn upon for the formation of sugar, the usual medicinal treatment is quite ineffective.

The primary stage of diabetes is most amenable to spa treatment, and to this end diabetic patients mostly betake themselves to Carlsbad. It would be illusory to discuss the question as to why the Carlsbad springs produce a beneficial effect in diabetes, whilst the same effect cannot be obtained by administering the principal ingredients of the Carlsbad waters at home. The fact remains that these waters relieve and in some cases cure the patient, whereas as alkaline drugs they often produce no appreciative effect. It must also be owned that analytical chemistry has not yet succeeded in discovering the exact proportion of the ingredients contained by the mineral waters; all that can be stated with certainty is, that they contain parts of sodium, potassium and magnesium, &c. It is, however, unable to certify the definite amount of the separate chemical combinations of these elements. In this instance the trustworthiness of analytical chemistry is a limited one, and only when this science shall have progressed so far as to be in a position to establish absolute certainty with regard to the exact proportions of each ingredient contained in the waters shall we be justified in seeking to replace Nature by artificial methods, and such certainty must extend to the ingredients of which only traces are present. These traces play a very important part in pharmacological research, as the famous French pharmacologist, Legrine, has shown that trifling quantities of several drugs when taken separately are quite ineffective, but when combined they may act more efficaciously than a large dose of a single drug. Leaving this question alone, I shall only rely upon the experience gathered from over 300 cases which have come under my care here, in most of which the result obtained was a satisfactory one.

As a general rule, the patient is first placed upon a diet which is almost free from carbohydrates, and takes from two to three tumblerfuls of the Carlsbad waters. In the majority of cases the most annoying symptoms—thirst and polyuria—disappear on the fourth or fifth day of treatment; the amount of sugar diminishes likewise, and in the course of the second week the urine becomes free from sugar. When this state of the urine is reached some liberal dietary allowances are made, i.e., the amount of carbohydrates is gradually increased as long as the limit of the patient's assimilative power is reached. It is very important to decide exactly this point, as a too severe diet in a system which has regained the capacity of assimilating a certain amount of carbohydrates is rather detrimental, and may result in loss of flesh and strength. The treatment in Carlsbad usually lasts from four to five weeks, at the end of which the patient is advised to live on the diet which has been prescribed in the last week of the treatment the whole year around, and in most cases patients are advised to take the Carlsbad waters at home after five or six months have elapsed since their treatment in Carlsbad. If the regimen is

properly carried out and the course of treatment is annually repeated in some cases restitution *ad integrum*, viz., restitution of normal assimilation, may be obtained; in other cases it will only prove capable of limiting the progress of the disease and prevent its development into the secondary stage. In this latter stage the results obtained by the Carlsbad treatment are less favourable. I noticed, however, an improvement of the subjective symptoms i.e., thirst, bulimia, polyuria, and irritability, and in the majority of cases acetone and diacetic acid disappeared in the course of the second or third week of treatment, whereas the disappearance of sugar was much more slowly effected than in the former group of cases, though a considerable diminution took place in each individual case. I may say in most cases belonging to the secondary stage a metamorphosis into the primary stage could be effected, whereby a considerable increase of the bodily weight and general well-being were distinctly noticeable. In the secondary stage the total restriction of carbohydrates is necessary, as if this regimen were followed, rapid emaciation and aggravation of the general symptoms, with an increase of acetone and diacetic acids, would ensue. In these cases I usually prescribe a more generous diet than in the primary stage, combined with a more energetic drinking treatment, and eventually obtain a diacetic urine free from acetone and diacetic acid. When this stage is reached, I start by-and-by to reduce the amount of carbohydrates, which practice is continued as long as the reduction of the amount of sugar is not accompanied by the reappearance of acetone and diacetic acid. As soon as these products reappear in the urine a further withdrawal of carbohydrates becomes necessary, and the amount preceding the reappearance of above products must be prescribed. I very often found that patients can better stand 1 or 2 per cent. sugar than traces of diacetic acid; and loss of flesh was noticed in cases with trifling amounts of sugar with the co-existence of acetone and diacetic acid, and as soon as these substances could not be traced in spite of the simultaneous increase of glucose, general improvement was noticeable.

In the secondary stage of diabetes I must emphatically recommend that advice be given to patients to take the Carlsbad waters during four or five weeks, three times a year, whereby in most of the cases the ailment will be reconducted to its primary stage. It will therefore be necessary to send the patient once a year to Carlsbad, and recommend him to take another course of the waters every four months at home. A very important action of these waters is their capacity of improving the digestion. The limited diet to which diabetic patients are confined, as well as the usually increased appetite, require greater activity on the part of the digestive organs, which for a time succeed in performing the additional labour imposed upon them, until their powers prove unequal to the task demanded from them, and deprive the patients of the only means of struggling against their consumptive disease, viz., a strengthening and suitable diet. In such cases the Carlsbad treatment becomes urgently necessary, and if employed the balance of health soon becomes re-established.

As mentioned before, the result largely depends upon the diet, and this circumstance, too, speaks in favour of Carlsbad, which, having become the meeting-place of diabetic patients, the treatment of diabetes developed into a certain kind of speciality, and, moreover, it is an undeniable fact that patients who often object to restrictions at home readily consent to them if far from their homes, and thus acquire a certain amount of guidance in the life they are going to lead in future.

The treatment is usually completed by baths, for which purpose hot mineral and mud baths increasing the bodily temperature are employed. These beneficially influence the eliminative organs by increasing perspiration and by decreasing diuresis, and, on the other hand, provide better sanitary conditions for the skin, which in diabetes is liable to pathological changes. In very mild cases, and especially in the transient

glycosuria of neurotics, hydropathic treatment is also of some value. Massage and bodily exercise are very useful adjuvants; it must, however, be borne in mind that both may become detrimental if overdone. Climatic influences are also of great importance, as it is a well-known fact that diabetics are extremely irritable, and are on the whole more accessible to noxious influences than other people; it will be, therefore, advisable to let such patients (if they can afford it) spend the colder season of the year in a warmer climate.

In many cases, where patients are prevented, either on account of the season or owing to their state of health, from visiting Carlsbad, the question arises as to whether the treatment can be performed at home. In reply to this question I must say that there is a vast difference between the action of the waters when taken at Carlsbad and taken at home. It goes without saying that the waters of thermal springs, even when bottled as they are with minute care and transported at the greatest speed, lose a certain proportion of their chemical activity, and it is therefore conceivable that this may contribute towards a reduction of the beneficial effects of the waters. Still, it would be undoubtedly wiser to take the waters at home than not to take them at all, experience having proved to me that the bottled waters provided great relief and completed the cure of many patients who, after having gone through a course of treatment at Carlsbad, required an "after-cure" by means of the waters at home. This "home-cure" should, of course, be prescribed and watched over by a physician, and be associated with dietetic and bath treatment. The waters should be taken early in the morning and on an empty stomach, to be immediately followed by constitutional walks. It is important that the water be warmed up to its original temperature, and that the patient should start with small quantities, viz., one tumblerful, which may be increased by and up to three or four tumblerful. In cases of constipation it will be necessary to add from one to two teaspoonsful of the natural Carlsbad Sprudel salt to the first tumbler of water. As a substitute for the bath treatment luke warm or hot baths as well as Turkish and electric light baths may be employed, and at the same time it is advisable to let the patient have plenty of fresh air and as much exercise as his case requires.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON.
MEETING HELD MARCH 24TH, 1905.

The President, DR. FREDERICK TAYLOR, in the Chair.

DR. NORMAN DALTON and Mr. A. D. REID read a paper on

A METHOD OF ASCERTAINING THE POSITION AND SIZE OF THE STOMACH BY MEANS OF THE X-RAYS AND A TUBE FILLED WITH SUBNITRATE OF BISMUTH.

The method had only been employed in those cases in which an empty stomach tube would be used for diagnosis or treatment. The method was as follows: The ordinary stomach tube was passed once a day for two or three days beforehand so as to accustom the patient to its presence in the stomach. The stomach being empty, the patient lay on his back, while the X-rays were situated beneath the couch. The bismuth tube is then slowly passed into the stomach while the epigastrium is watched through the fluorescent screen. In a typical case the tube could be seen to emerge from beneath the ribs a little to the left of the middle line, and then to descend until it reached the greater curvature of the stomach rather to the left of the umbilicus. Then the point of the tube slid upwards and to the right along the pyloric end of the greater curvature, while the stem became convex towards the left. When the point became arrested at the pylorus, the rest of the tube adapted itself to the greater curvature, and the photograph of it in that position gives practically a representation of

the greater curvature. The umbilicus was marked out by a metal disc and the curve of the ribs by metal wire so as to give bearing points. Lantern slides taken from the photographs were exhibited, showing the tube in various positions in the stomach. In one the curve and position of the tube indicated gastropnoxis. This was verified at an operation for gastro-jejunosomy. In another it showed great gastropnoxis with gastrectasis. In another, moderate gastrectasis, which was found at an operation to be present and to be due to old pyloric adhesions. In another, great gastrectasis. In one case the point of the tube was permanently arrested at a position close to the umbilicus, and it was found at the operation that the pylorus was actually situated there, being enveloped in a dense mass of adhesions. Subsequent experiments showed that in the cadaver the tube pushed the greater curvature before it, so that the point did not ascend towards the pylorus, but remained at the umbilicus. It is therefore probable that in an extremely atonic stomach the tube would not pass beyond a point corresponding to the umbilicus. Slight retching on the part of the patient will often disengage the point of the tube and facilitate its gliding movement up to the pylorus. Great retching, of course, prevents the photograph from being taken, but does not interfere with what is seen through the fluorescent screen. In other cases it had been proved at operation that the curve of the tube gave a faithful delineation of the greater curvature. No photograph of the tube in a normal stomach had yet been obtained, because so much of the stomach is covered by the ribs, diaphragm, and left lobe of the liver that the shadow is faint. In one case the tube was distinctly seen, and its position and curve indicated that the stomach was normal in these two respects, and the operation showed that such was the case; but the photograph was not successful. The tube was as flexible as an empty one, but heavier. It had not been possible to procure one which is quite as long as is desirable. It was as safe as the empty tube, and it shows well the size and position and sometimes also the shape of the stomach when empty; whereas the injection of air or fluid may considerably stretch the viscus. The method certainly enabled one to recommend an operation with the greatest confidence.

Remarks by Mr. Reid.—The technique of taking the skiagrams was as follows:—The patient is laid on his back on a canvas-topped couch underneath which the tube is mounted on a double slide which allows movement longitudinally and transversely, thus rendering it easy to centre it under any given spot. The tube is enclosed in an opaque box with an adjustable circular diaphragm placed over a 3-inch aperture opposite the anode, the smallest diaphragm being used that will include the required area. When the bismuth tube has been inserted as far as it will go, the patient is directed to hold his breath, and the exposure of from 10 to 20 seconds made, the plate being placed on the abdomen. The apparatus must be powerful to enable a sufficiently good skiagram to be taken in this time; that used in taking those shown consisted of a 10-inch variable primary coil worked off the 100 volt continuous main, with an electrolytic interrupter working at 15 amperes on the primary of the coil, and either a heavy anode or water-cooled tube.

Mr. MCGAVIN queried whether the stomach would not be displaced by the tube in the living person, as it is in the dead.

Sir DYCE DUCKWORTH imagined that such displacement would depend on the pressure exerted. He was more doubtful as to whether the tube followed exactly the greater curvature of the stomach.

Dr. NORMAN DALTON, in reply, said that the stomach wall might be displaced by the point of the tube, but could not be displaced when the tube was lying flat and parallel to the wall. No pressure could be exerted on the stomach wall as the tube at once curved flat.

Mr. DOUGLAS DREW read notes of three cases of

STENOSIS OF THE URETER,

upon which he had operated. *Case I.*—Congenital narrowing of the upper end of the ureter causing hydronephrosis. It was treated by incising the stenosed portion of the ureter and suturing it to the adjacent part of the pelvis (pyelo-uretero-plasty), this resulting in a cure. *Case II.* was of a similar nature to the first, but the narrowing affected the upper four inches, which were exposed. The kidney itself was but little affected, although the pelvis contained 2½ ozs. of urinous fluid. The condition of the ureter was not remediable; at the same time, it did not appear desirable to sacrifice the kidney. The ureteral orifice was enlarged as in Case I, in the hope that it might be enough to cure the hydronephrosis, but within three weeks the tumour made its reappearance and will require nephrectomy as it is causing pain. *Case III.*—Pyonephrosis from calculi impacted in ureter—nephrotomy and ureterotomy, subsequently nephrectomy, owing to stenosis of ureter. After evacuating the pus from the kidney, the ureter was exposed, as no cause was found in the organ to account for the condition. A fusiform enlargement was found upon it one inch from the pelvis. On incising this, three minute calculi were found embedded in granulation tissue lining the ureter. The kidney was drained for three months, during which time no pus was present in the urine, thus indicating that it was obstructed, and as the sinus would not heal, nephrectomy was performed, and the patient made a satisfactory recovery. The kidney and ureter, together with the calculi, were exhibited. Mr. Drew remarked on the importance of exploring the ureter in cases of hydro- and pyonephrosis when the cause of the condition is not found in the kidney.

Mr. A. E. BARKER confirmed Mr. Drew's remarks as to the rarity of stenosis low down in the ureter. He had, however, seen many cases of stenosis of the upper part, due either to stone or to congenital malformation. He advocated passing a catheter from the pelvis into the bladder, and out at the urethra, so as to maintain a wide lumen in the stenosed portion.

Mr. WALTER SPENCER pointed out how curious it was that a congenital lesion should not produce symptoms till so late in life. All the cases were in women, so possibly the stenosis was a cicatricial one due to minor infection after labour.

Mr. DREW, in reply, stated that there was no evidence of sepsis in the narrow portion, which together with the absence of peri-ureteritis negatived Mr. Spencer's suggestion.

Mr. ARTHUR E. BARKER described three cases illustrating the

CONDITION OF THE SMALL INTESTINE SOME YEARS AFTER EXTENSIVE ENTERECTOMIES.

The cases put on record were to show that the condition of paresis of the intestine commonly seen about an acute obstruction is not completely relieved by the release of the constriction, but may persist more or less for years, a point apparently hitherto overlooked. The two first cases were operated on respectively 2½ years and 21 months before a second operation involving laparotomy had to be done. In both, large tracts of small intestine had to be removed and each showed at the second operation that the bowel above the anastomosis had not yet returned to its normal size or activity as contrasted with the part below the junction. The author attributed this weakening and thinning of the proximal portion not only to the distension of the gut above the obstruction, but to the saturation of all the coats and nerves with toxins developed in the fermenting bowel contents. Reasons for this conclusion were given, and their bearing on practice. The third case, which had been operated on two years before for obstruction, showed the same condition. Here the obstruction had not been relieved, but a "short circuit" of the small intestine to the sigmoid flexure had been made, with return to the best of health and normal action of the bowels. Nevertheless, there was clear evidence of atony of the bowel and thinning of its walls two years later when the

second operation was done. Some suggestions as to the typical procedure in such cases concluded the paper.

Mr. MALCOLM asked whether the existence of a cicatrix in the intestinal wall was a cause of distension, owing to its possible interference with peristalsis.

Mr. W. C. SPENCER commented on the extraordinary success of Mr. Barker's long enterectomies, and was sure that in the past too little gut had been removed in these cases by most surgeons.

Mr. BARKER, in reply, mentioned that there was no increase of shock when extensive enterectomies were performed.

Sir DYCE DUCKWORTH and Mr. C. M. HINDS HOWELL on a case of

STREPTOCOCCAL PACHYMENINGITIS.

The patient, æt. 14, was admitted to hospital on November 14th, 1904. There was a history of eighteen days' indisposition, with headache and occasional vomiting, previous to his admission. Temperature on admission was 102° F., the pulse 90. Patient was very irritable and complained of pain behind left ear, but nothing abnormal was found on examination of ears. A trace of albumin was present. Nothing abnormal was noted in the nervous system, beyond an increased weakness in the knee-jerks. On November 21st, there was increased amount of albumin in urine, with blood and casts. The leucocyte count was 15,400. Slight twitchings of face were noticed. Cerebral irritation had increased; all food was given by nasal tube. On November 24th: Cheyne-Stokes' breathing, paresis of right side of face, ankle-clonus, Babinski and Kernig signs were present. Dyspnoic attacks followed on November 25th, and pulse became irregular; on November 27th patient became comatose and died. The temperature from admission, November 14th to November 23rd, varied little from 103° F., but fell the last two days of life. The pulse frequency was about 80-90 throughout, only becoming irregular at the end. The *post-mortem* examination showed a large quantity of pus over the vertex, subdural in position. The pia-arachnoid was natural. The surface of the brain was furrowed deeply from pressure of the pus, which was found bacteriologically to be streptococcal. A pyæmic abscess was present in the lung. The brain was exhibited before the Society.

Dr. DALTON asked whether the nasal sinuses had been examined *post-mortem*. He had seen such a case latterly where the nasal sinus was the seat of primary infection.

Sir DYCE DUCKWORTH said that the sinuses had not been examined.

ROYAL ACADEMY OF MEDICINE IN IRELAND. SECTION OF OBSTETRICS.

MEETING HELD FRIDAY, MARCH 10TH, 1905.

The President, ALFRED J. SMITH, M.B., F.R.C.S.I., in the Chair.

SPECIMENS.

DR. E. HASTINGS TWEEDY.—Tubo-ovarian abscess; myoma of broad ligament removed by myomectomy; maldevelopment of large intestine—enterostomy; ovarian cystoma.

Dr. PUREFOY thought the first specimen was a very interesting one from the point of view of the possibility of making a correct diagnosis before operation. He did not quite agree that the fact that a woman was pregnant three months before negatived double pyosalpinx. The specimen from the infant was also a very interesting one, especially as to what led to its development. Speed in operation was always important. He had read with surprise that Spencer Wells, even in his day, could do an ovariectomy in fifteen minutes.

Dr. JELLETT said the intestinal specimen was one of great interest, and described a somewhat similar case which he had operated on whilst in the Rotunda. The child was born with a largely distended abdomen, and passed no meconium. He opened the abdomen in

the middle line, and came straight into a cavity, from which came a large quantity of meconium. The child lived for a couple of days, and the *post-mortem* showed that the cavity was an enormously distended cæcum, beyond which there was practically no bowel.

Dr. KIRKPATRICK said he had dissected the body of a new-born infant which had suffered from intestinal obstruction. The abdomen was occupied by a cyst or cavity containing meconium, and the small intestine opened into it. Below this dilated portion of the intestine there was a volvulus, below which the colon was contracted practically to a cord.

Dr. HASTINGS TWEEDY, during his reply, said that in the ovarian case he had stitched the abdominal wall in three layers, and while performing the operation (which occupied twelve minutes from the first incision to the last stitch) he had no idea of working against time.

Dr. HENRY WILSON.—Fibro-myomatous tumour excised from labium majus; uterus removed by panhysterectomy for adenoma malignum.

Dr. TWEEDY asked Dr. Wilson what had determined him to perform an abdominal rather than a vaginal operation.

Dr. PUREFOY said that the first case was very interesting, partly on account of the great rarity of fibroid tumours in that locality, and also because, until the tumour becomes ulcerated, its real nature may be undetermined. Winckel mentions a case where the tumour, after remaining for seven years, eventually proved to be sarcomatous. He asked if any microscopic examination had been made of the tumour.

Dr. WILSON said he might have operated by the vaginal route, but owing to the woman being a nullipara, he had thought the abdominal operation would be easier.

Dr. JELLETT showed an infant on whom cleidotomy had been performed in consequence of impaction of the shoulders at the pelvic brim. Traction failed to deliver, and so cleidotomy was performed. Traction still failed, and so the posterior muscular attachments of the scapula were divided. This enabled the whole scapula and shoulders to move forward on to the chest, and delivery was then easily accomplished. The foetus measured 45 cms. round the shoulder girdle with the shoulders in their normal position, and 34 cms. when compressed after the division of the bones and soft parts.

Dr. HORNE said the case reminded him of a similar one which had occurred with him a year ago. The patient gave a history of the first labour being extremely difficult. He could find no distinct narrowing of any portion of the pelvis, and allowed her to go on to full term. The labour was very slow, and the head had to be extracted with forceps. He failed to deliver the shoulders by traction, and finally got his hand up on the posterior wall of the pelvis, and a finger into the axilla. After a great deal of traction he got down one arm, and completed delivery. He thought Dr. Jellett's operation a very ingenious one.

Dr. PUREFOY said that one of the many points in the case was the way it illustrated the fact that pregnancy might be unduly prolonged, and the consequent increase in the size of the child might be serious. Some years ago he assisted at a case of delay in labour. The head was in the pelvis, and several attempts had been made to extract it, but in vain. He suggested waiting to allow moulding to take place. After some hours he attempted delivery with forceps, but could not move the head till he had perforated it. The extraction of the shoulders caused great difficulty until he passed a blunt hook into the axilla, and completed delivery.

Dr. GLENN thought the lesson to be learned from the case was that when a child could be lost by a skilled obstetrician one ought to look charitably on such accidents in the hands of the general practitioner. He asked Dr. Jellett (1) if he had tried a screwing motion with one hand on the back and one hand on the chest of the child to try and rotate it. Occasionally this changed the position of the arms, and allowed of extraction. (2) Why did he not use Braun's blunt

hook? Though quite aware of the danger of this instrument in unskilled hands, yet it undoubtedly had its uses. The period of gestation in most of these cases was over the usual period. He thought Dr. Jellett was to be congratulated on saving the mother.

Dr. JELLETT, in his reply, said that the use of the blunt hook was extremely difficult and dangerous. In doing the cleidotomy he spent about three minutes over each clavicle and about five minutes in separating the posterior attachments of the scapula. There was no bruising of parts and consequently the question of saving the mother did not arise, as her life was never in danger. The rotation of the body he considered an admirable suggestion. It did not occur to him, but probably would have if he could have got at the body. It might have brought about the same result as the division of the scapular attachments. In regard to the period of gestation, there certainly seemed, in this case, to have been a prolongation.

A CURATIVE OPERATION FOR PROCIDENTIA UTERI.

Dr. HASTINGS TWEEDY read a paper on this subject, and called attention to a suggestion lately put forward to remedy this diseased condition. He did not believe that any procedure having for its object the removal of the uterus and the entire closure of the vagina provided a sound surgical remedy. He had on three occasions performed an operation that appeared to him on theoretical grounds to fulfil all the requirements of a complete cure in the worst conditions of prolapse. Briefly stated, the operation consists of opening into the abdomen, both in front of and behind the cervix. This enables the operator to grasp the broad ligaments between thumb and forefinger, and protect the ureters and uterine artery, whilst the bases of the broad ligaments are denuded by stripping the vaginal mucous membrane of the lateral fornices from them. Ligatures are passed through these structures close to their pelvic extremities, and these ligatures when tied together in front of the cervix will cause the latter to be elevated in an upward and backward direction. The basal fibrous structures (Mackenrodt's ligaments) are still further secured in front of the uterus, in the neighbourhood of the internal os, by several fine sutures. The final steps of the operation consist of amputation of cervix, anterior vaginal fixation of the uterus, and an anterior colporrhaphy, combined with Hegar's colpo-perineorrhaphy.

Dr. GLENN said that the original operator passed the stitch through the back of the cervix, and drew it upwards and backwards towards the promontory of the sacrum, the fundus falling forwards. An anterior fixation was also done.

Dr. JELLETT said that in many cases of prolapse some form of operation was necessary. He was in favour of vaginal fixation and some form of narrowing operation of the vagina. He had no dread of pregnancy afterwards, never having had any trouble. He had lately opened an abdomen in which anterior fixation had been previously done, and it had had excellent results. He thought that that operation, *plus* narrowing, was usually quite sufficient, and if not, Dr. Tweedy's operation was an excellent one, as it was on a sound anatomical basis, and got the uterus anteverted, &c., and at its normal level.

Dr. PUREFOY said the subject was one of great interest, as some of those cases might be the start of a fatal illness. He had seen one case of peritonitis resulting from a case. With regard to the various structures which kept the uterus in position, there was some difference of opinion. In Dr. Savage's book there is a series of plates on the subject, and he demonstrates that the structures which chiefly prevent procidentia are the utero-sacral ligaments. The procedure which Dr. Tweedy had shown was in certain cases an excellent one, but was manifestly not suited to all cases of procidentia. Huguier pointed out that in many cases hypertrophy of the cervix was the cause of procidentia, and this could be dealt with by amputation of the cervix.

Dr. A. J. SMITH said that he had found the necessity for some trustworthy operation for procidentia. He

had read the original description of the operation, but had thought it exceedingly theoretical. He had not seen how, in tying the sutures, you avoided compressing the ureters, and he was delighted to hear of Dr. Tweedy's favourable results. He was quite at one with Dr. Jellett with regard to the value of vaginal fixation—*plus* the ordinary colporrhaphy—in ordinary cases of prolapse. It gave very good results. He had also got good results from abdominal fixation.

Dr. TWEEDY, in reply, said he was exceedingly obliged for the favourable way the Section had received the operation. He felt that there were great possibilities in it. Vaginal fixation was not sufficient in the worst forms of prolapse, and he was not at all so convinced as Dr. Jellett that the results of a subsequent pregnancy in all cases would be what one would like. The operation when performed in an ideal manner would give admirable results in pregnancy, but cases were met with in which, before the uterus could be brought forward, one had inflicted such injuries on it that firm adhesions would form. Like Dr. Purefoy, he had formerly attached enormous importance to the sacro-uterine ligaments, but he had now adopted the view that the ligaments he had pointed out were perhaps of more importance in keeping the uterus in proper position, especially in that of elevation. There was frequently a deep laceration of the cervix in bad cases of procidentia, and in such cases Mackenrodt's ligaments were probably torn.

ULSTER MEDICAL SOCIETY.

MEETING HELD IN THE MEDICAL INSTITUTE, BELFAST, ON THURSDAY EVENING, MARCH 23RD.

The President, Dr. CALWELL, in the Chair.

On the motion of Dr. DARLING, seconded by Dr. MCKISACK, a resolution was unanimously passed congratulating Dr. Darnell, of Bangor, a Fellow of the Society, on the verdict in his favour in the recent annoying and troublesome action brought against him by a patient.

Mr. T. S. KIRK read a paper on "Some Cases of Perforation of the Stomach and Intestines," which will be found on page 321. In the discussion that followed

Mr. A. B. MITCHELL congratulated Mr. Kirk on his brilliant results. He had operated on about twenty-one cases himself, the first three being all over thirty hours after the rupture, and all three fatal. In subsequent operations he had got good results, but not so good as these of Mr. Kirk's. He agreed as to great importance of early operation. With regard to opium, he saw the necessity for its use to allay acute pain, but he thought only small doses should be given, repeated if necessary. This plan was ultimately better for the patient. When vomiting was seen, it was well to remember that while it might occur once or twice in a rupture case, where one found persistent vomiting it was not likely to be a case of rupture of the stomach or duodenum.

Dr. DARLING (Lurgan) discussed the use of opium, and the pitfalls in early diagnosis.

Dr. CAMPBELL said he was in thorough agreement with Mr. Kirk in most points, but differed about washing out. He used to sponge only, but now washed out, using twelve or fourteen gallons of water, and doing it thoroughly. Possibly very early cases might do with sponging only, but in later cases he considered it absolutely essential to wash out, and Mr. Kirk's latest case, No. 6, he thought was a proof of this.

Dr. MCKISACK said he supposed that the physicians might still put in a word, and he wished to discuss the question of early diagnosis. He thought fluid in the abdomen was an important sign, since the majority of ruptures occurred when the stomach was full.

Mr. FULLERTON agreed with Dr. Campbell about washing out the abdomen, and added point to his remarks by requesting them to remember that if any of them had to open him, he wished to be washed out.

The PRESIDENT discussing the question of diagnosis, said he believed there were really two types, one a real

perforation, and the other a tear when the stomach is adhering to some other structure. If this were so, it might be that tears sometimes occurred without actually opening the stomach, and this might explain those cases where the symptoms pointed to a rupture, but none was found.

Mr. KIRK, in a brief reply, thanked his critics for their complimentary remarks, and referred again to the subject of washing out the abdomen.

Professor Symmens, Queen's College, was elected a Fellow of the Society.

LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD MARCH 16TH, 1905.

DR. JAMES BARR, the President, in the Chair.

DR. FRANK H. BARENDT showed a patient, *æt.* 33, suffering from "Prurigo Ferox." The primary efflorescences were obscured to some extent by the scratched skin. The femoral, cubital, and axillary glands were enlarged. The man was able to do a little work, but owing to the lassitude from want of sleep, he was obliged to rest at intervals of three to four days. He never remembered falling to sleep without having to scratch himself, and when the itching was most severe two or even three hours elapsed before his scratching ended in sleep.

Mr. EDGAR STEVENSON related a case of "Orbital Exostosis," which occurred in a girl, *æt.* 22. The tumour had produced marked proptosis downwards and outwards in the left eye. It had been noticed by the patient for six months. At the operation for its removal it was found to be attached to the inner angle of the orbit with its base in the frontal sinus. The base was not very broad and the growth was wrenched away without difficulty. It was of an irregular pear shape, and measured one and a half inch in its largest diameter. The patient made an excellent recovery.

Dr. K. A. GROSSMANN congratulated Mr. Stevenson on being able to retain the function of the eye after the removal of the exostosis. He referred to a case he had operated upon three years ago.

Mr. G. G. HAMILTON described a method of wiring fractured patellæ transversely, and related ten cases which he had thus operated upon. The patients were exhibited, and demonstrated by the free movements of the joints the excellent results that had been obtained. In one of the patients both patellæ had been wired. In every instance the men had been able to resume their former occupation, the function of the joints being normal in every respect.

Mr. RUSHTON PARKER said that the results obtained certainly justified the operation. At the same time, operation should not be recommended indiscriminately, for it did not seem to be sufficiently recognised that good results could be obtained without any operation.

Dr. T. R. BRADSHAW showed a man, *æt.* 54, with symptoms of "Syringomyelia," which first appeared fifteen years ago. The lumbar enlargement was chiefly involved. There were present wasting and atrophy of the anterior tibial muscles with foot- and toe-drop, trophic changes consisting of painless ulceration and eruptions on the legs and feet and curious deformities of the toes, and loss of painful and thermic sensations below the knee, in the region corresponding to the fourth and fifth lumbar segments, and the first sacral. Tactile sensibility was normal. The plantar and patellar reflexes were abolished. There was some loss of thermic sense in the right hand, and some stiffness of the fingers of both hands. There were no sphincter or visceral troubles. Dr. Bradshaw pointed out that the complexus of symptoms was characteristic of syringomyelia, but the case was atypical in the advanced age of the patient, and in the greater involvement of the lumbar than of the cervical region.

The PRESIDENT proposed a resolution congratulating Dr. A. T. H. Waters on having attained his Jubilee of membership, which was seconded by Dr. W. Carter, and carried with acclamation.

Dr. WATERS delivered a most interesting address on "Some Notes and Reminiscences."

LARYNGOLOGICAL SOCIETY OF LONDON.

ON March 17th, the day of the Garcia Centenary, an ordinary meeting of the Society was held at No. 20 Hanover Square, when a large collection of pathological specimens also were exhibited. The meeting was very largely attended, and the following distinguished foreign laryngologists were present: Professors Gluck, Moure, Poli, Botella, Chiari, and Koenig.

Mr. PARKER showed a case of "Tuberculosis of the Larynx in a Woman, *æt.* 31, complicated with Pregnancy," the patient having also been shown at the February meeting.

Dr. TILLEY brought a series of patients upon whom radical operations had been performed for the cure of chronic empyemata of the frontal and other nasal accessory cavities.

Mr. DE SANTI showed a woman, *æt.* 35, with "Pharyngo-laryngeal Epithelioma," and opinions were asked as to the advisability of operation.

Professor GLUCK advised operation, but the majority of members were of the opinion that the growth was too extensive.

Sir FELIX SEMON showed a case of "Soft Fibroma of the Larynx and Neck," which was removed by external operation, without opening the cavity of the larynx.

Mr. CHARTERS SYMONDS showed a successful case of "Total Laryngectomy," in a man, *æt.* 52, which was operated upon nine months ago.

Dr. STCLAIR THOMSON showed two cases, one of "Epithelioma of the Larynx," in a patient, *æt.* 49, laryngo-fissure having been performed eight months ago, and there was no recurrence. This man had pulmonary tuberculosis, which was arrested twelve years ago, after injections of tuberculin. The second case was one of "Primary Lupus of the Larynx and Pharynx," in a girl, *æt.* 22, which was nearly healed.

Dr. EDWARD LAW showed a case, from the previous meeting, of "Incrustation in the Trachea," in a woman.

Dr. WILLIAM MILLIGAN exhibited a beautiful series of micro-photographs of pathological specimens.

Dr. ATWOOD THORNE and Mr. LUNN showed a case of "Epithelioma of the Nose," with specimens and photographs.

Mr. H. B. ROBINSON showed a woman with "Cicatricial Diaphragm," of specific origin, passing from the posterior third of the tongue to the posterior wall of the pharynx.

Dr. DUNDAS GRANT showed a case of "Supposed Pharyngeal Pouch Opening into the Right Hyoid Fossa," with a radiograph of the pouch when filled with bismuth.

Dr. H. J. DAVIS showed a case of "Fixation of the Left Vocal Cord in a man, *æt.* 50, with pulsating Aortic Aneurysm."

Dr. LAMBERT LACK showed two cases of "Epithelioma of the Larynx, Pharynx, and Base of the Tongue." Extensive operation was performed, the glands in both anterior triangles were removed, and the patient cured. Both these cases had been previously pronounced inoperable.

Mr. BARWELL showed two cases of "Tuberculous Laryngitis," which healed under treatment.

Dr. WATSON WILLIAMS showed a case of "Cerebro-spinal Rhinorrhœa," and one of "Posterior Ethmoidal and Sphenoidal Sinus Disease," where the ethmoidal cells had been laid open and the disease eradicated.

On Saturday, the 18th inst., Professor GLUCK demonstrated his method of performing total extirpation of the larynx.

CENTRAL MIDWIVES BOARD.

MEETING HELD THURSDAY, MARCH 23RD, 1905.

DR. CHAMPNEYS, President, in the Chair.

DR. CHAMPNEYS opened the proceedings by expressing his regret at the resignation of Dr. Cullingworth, and a vote of thanks was unanimously carried to that gentleman for services rendered to the Board.

Letters were read from the Royal College of Physicians reporting the re-election of Dr. Champneys, and

from the Royal College of Surgeons reporting the reelection of Mr. J. Ward Cousins as representatives for the year beginning April 1st next. The intention of the Society of Apothecaries to send a representative was intimated, also the election of Dr. W. R. Dakin as representative of the Incorporated Midwives Institute.

The Secretary then read a letter from the C.C. clerk (West Riding) suggesting on behalf of the Council a reduction of the certificate fee to 2s. 6d. or less, but it was resolved by the Board to reply that the sum adopted had not hitherto seemed prohibitive.

Sir WM. SINCLAIR, with regard to two letters from Liverpool University and the Ladies' Charity and Lying-in Hospital, asking for that town to be made an examination centre, remarked that it was an easy and cheap journey to Manchester; that it was dangerous to multiply centres, and possibly the request arose from a little jealousy of the sister town. Further consideration was postponed.

A request was then read from the Clerk of the Menai Bridge U.D.C. suggesting the desirability of having the Board's rules translated into Welsh. Dr. CULLINGWORTH and Miss PAGET were of opinion that the request was a reasonable one, but

Sir WM. SINCLAIR objected, urging that the next demand would be for examinations in Welsh, and permission on the part of midwives to send in notes of cases in that tongue. He believed it was simply an expression of Welsh nationalism. They could speak English quite well.

Dr. WARD COUSINS moved for an official translation rather than leave the rules to local treatment, and it was finally decided to find out the necessity, if any, for translation.

Dr. Sergeant, M.O.H., Lancashire, wrote asking if a midwife could be reproved or suspended for not calling in a doctor when there was rise of temperature, loss of blood, abortion, &c. [Rule E. 17, (c) I (5) and E. 7.]

Dr. CHAMPNEYS remarked that in case of accident if temperature and pulse had not been noted, the Council would blame the midwife, and

Sir WM. SINCLAIR added that carefulness in seeing that the nurse so acted was the only safeguard the local superintending authorities had against puerperal fever. It was agreed to reply that neglect in any particular named constituted an offence, Miss PAGET adding a recommendation that all antiseptics ought to be provided at the expense of local authorities.

Sir WM. SINCLAIR then moved: "That the advertisement issued by the Board in pursuance of a resolution of January 26th be withdrawn, and the question of the appointment of an Inspector be further considered by the Board." He urged in support of his motion that undue haste had been made: that there was no need to appoint an Inspector in such a hurry, and no regard had been shown for the feelings of the medical profession in the way a "medical woman" had been advertised for. He would further move that the present Inspector be given notice on the grounds that her appointment was not found to assist with advantage the acting of the Board. It was absurd, moreover, to send a young medical woman at the very poorest fee—one guinea—to a town where she would have to stay perhaps three days; to lose her practice during that period and not have time to inquire thoroughly into facts. She might, perhaps, do so in a small village, aided by gossip, but why send a medical woman when the M.O.H. could supply, being resident, an ample report for, say, three guineas? He would protest also against the frequent meetings of the Board, which hardly showed consideration for country members.

Dr. CHAMPNEYS remarked that although Sir William had known of the measure to be taken he had not written; to which Sir WM. SINCLAIR replied he had spoken about the matter several times.

Dr. PARKER reminded the Chairman that on the occasion of the resolution he had strongly opposed the term "medical woman," and suggested "legally qualified practitioner," which would include both men

and women. Unfortunately, he had been alone, as Dr. Ward Cousins, who shared his opinion, had had to leave. He (Dr. Parker) thought it might be well to see, having appointed an Inspector, how it answered, but would suggest making use of the local authorities.

It was agreed to discuss Sir Wm. Sinclair's motion at the next meeting, which will be held on April 27th. After consideration of applications for certificates, the names of 2,400 women were passed under Section 2 of the Act, and ordered for entry on the Roll.

The following table shows the separate numbers of the various qualifications at present appearing on the roll:—

Royal College of Physicians of Ireland ..	6
Obstetrical Society of London	5,453
Rotunda Hospital	317
Coombe Hospital	73
Queen Charlotte's Hospital	282
Liverpool Lying-in Hospital	211
British Lying-in Hospital	8
Glasgow Maternity Hospital	210
St. Mary's Hospital, Manchester	159
Manchester Maternity Hospital	47
City of London Lying-in Hospital	78
Royal Maternity Hospital, Manchester	89
Salvation Army Maternity Hospital	20
National Maternity Hospital, Dublin	18
Limerick Lying-in Hospital	10
Cork Lying-in Hospital	12
Eden Hospital, Calcutta	3
Newcastle-on-Tyne Lying-in Hospital	11
Dundee Maternity Hospital	23
Aberdeen Maternity Hospital	12
Women in <i>bonâ-fide</i> practice, July, 1901 ..	8,448

Total enrolled 15,590

Special Articles.

THE TEACHING OF HYGIENE AND TEMPERANCE.

THE medical profession very rightly demands to be heard when matters concerned with personal and public health are under discussion. It will be within the recollection of our readers that a petition in favour of instructing the children in our public elementary schools in the principles of hygiene and temperance was recently signed by nearly 15,000 medical practitioners in this country. An influential deputation also waited on Lord Londonderry to request that the Board of Education should arrange for the systematic presentation of such teaching. The Board of Education has thought fit to assume a reactionary attitude, and has issued a remarkable memorandum in which its adviser, Sir Michael Foster, K.C.B., M.P., expresses views which by many eminent authorities are considered physiologically unjustifiable and calculated to mislead local educational bodies. This document has called forth an important letter, which we are able to publish. It deserves serious consideration, and we understand has already gone far to alter the attitude of the educational authority in regard to this matter.

TO THE RIGHT HON. THE MARQUIS OF LONDONDERRY,

K.G.,

President of the Board of Education.

MY LORD.—We, the undersigned members of the medical profession, being specially interested in furthering the teaching of hygiene and temperance in the elementary schools, have had under our consideration a document issued by the Board of Education containing: (1) A Memorandum by Sir Michael Foster, M.P., criticising adversely paragraphs of "certain" syllabuses which have been employed in the teaching of elementary temperance and hygiene, and (2) Remarks thereon by the Board of Education. As the document nowhere gives the titles or sources of the syllabuses referred to by the Board and Sir Michael Foster, we are debarred from discussing them in their entirety and from reviewing the paragraphs in relation to their context. After a full consideration of the

document issued by the Board, we feel that an earnest and emphatic protest must be lodged against its adoption and circulation. By a misuse of physiological expressions and facts, Sir Michael Foster has conveyed in his memorandum an erroneous impression of the comparative effects produced upon the body by oxygen, water and alcohol, and we are strongly of opinion that his memorandum is calculated to mislead very seriously any educational authority to whom it may be sent. Sir Michael Foster asserts that if alcohol is to be spoken of as a poison, then also oxygen and water are both poisons. Now, oxygen and water, as they exist in Nature, are essential to animal life, but though Sir Michael Foster does not actually state that alcohol, itself an artificial product, is also essential, he endeavours to raise it to the same plane of harmlessness and utility. To force this unnatural conjunction further, after referring to the direct poisonous influence of alcohol and ether on the nervous system, he states that "distilled water similarly applied has a like injurious effect." The apparent significance of this assertion and, indeed, the entire tendency of this part of his memorandum, is to suggest that the action of distilled water on the nervous system is poisonous in the same sense as that of alcohol. Though there is no fear that such an obviously false assumption can be maintained in opposition to well-ascertained scientific facts and to practical experience, it is necessary to point out that Sir Michael Foster endeavours to establish his allegation by a misuse of a scientific experimental fact. By his allusion to water being "applied directly to the nerves," it is evident to those who are physiologists that he is referring to an experiment on an exposed nerve in which the injury is produced by the osmotic action of water on protoplasm. This experiment, however, has nothing to do with the effects which may be produced on the nervous system if water or alcohol respectively are taken into the stomach. By thus quoting a physical experiment in such a connection as to make it apparently apply to a totally different set of conditions, scientific truth is perverted and the issue completely confused. The next point to which detailed attention must be directed is Sir Michael Foster's reference to oxygen as being a poison as well as alcohol, and the deplorable effect which such a statement is calculated to produce on the minds of those technically unqualified to comprehend the actual facts. That this has already occurred is shown by the extraordinary complaint made by the Board on page 4 in the following terms: "Oxygen is regarded in the syllabuses as an essential of life. No reference is made to any dangerous (*sic*) properties." The obvious answer to this objection is first that oxygen is not regarded by the syllabuses only, but by the whole scientific world, as an essential of life, and, secondly, that as a component of fresh air it is well known to have no dangerous properties. The Board were possibly led into this position by Sir Michael Foster's distortion of scientific reasoning, for, as already shown, he implies that if alcohol is alluded to as a poison, oxygen ought to be also. In order to speak of oxygen in this manner he is compelled to admit that it has no injurious effect except at a pressure of four to six atmospheres, that is to say, on animals placed in a tightly-closed chamber into which is pumped oxygen at a pressure of sixty pounds and upwards per square inch, or air at a still higher pressure. We, therefore, consider that Sir Michael Foster's endeavour to thus construct a false analogy between oxygen and alcohol, and his reference to the properties of oxygen under very high pressure when its essential value as an ordinary constituent of the air we breathe was the real question, are both reprehensible, and we are confirmed in taking so grave a view of his attitude by seeing how completely the Board has been deceived. Though Sir Michael Foster's assertion on the effect of oxygen on the body is unlikely to mislead to the same extent the various educational authorities to whom it may be addressed, it appears to us deeply regrettable that the Board of Education, instead of condemning the sophistry of Sir Michael Foster's memorandum, has chosen to

endorse it. Moreover, we cannot pass over without protest Sir Michael Foster's equally misleading reference to "intoxicants." The syllabuses, as quoted by the Board of Education, give a perfectly correct scientific interpretation of what is meant by "intoxicating," but Sir Michael Foster does not hesitate to place together in this respect alcohol and theine, the active principle of tea, and, in fact, he says, "Both are intoxicants if taken each in an adequate dose." We desire to point out that, in our opinion, it is a grave error both of principle and fact to tell the children of elementary schools that tea and coffee are of the same intoxicating character as alcohol, and, further, as we are not aware of a published instance of anyone becoming intoxicated by tea, Sir Michael Foster should have supported his statement in his memorandum by informing the Board of Education what amount of tea a person would have to drink to obtain enough theine for the production of as much intoxication as could be secured by taking a quarter of a pint of alcohol. The word intoxicating, or intoxication, has a perfectly definite and well understood meaning in ordinary language, being always used in reference to drunkenness, and it is unjustifiable to apply it to any effects produced by tea.

In conclusion, some objection seems to have been taken by the Board to the fact that some of the syllabuses referred to have been couched in popular language. From the point of view of science, and physiological science especially, we desire to indicate to the Board of Education that it is still more misleading to attempt to convey in a short syllabus the divisions of scientific subjects in strictly technical terms. Inasmuch as the laws of hygiene and temperance are founded upon practical experience as well as upon the facts of scientific experiment, any scheme or syllabus designed for the purposes of education in these subjects ought to be drafted in general as well as in special terms.

In connection with this question of the framing of syllabuses and courses of lessons, we are glad to observe that the local educational authorities are recognising the value and importance of the efforts which have been made to introduce the teaching of hygiene and temperance in the elementary schools; we trust, therefore, that the Board of Education will help forward this essential reform and will not permit the difficulties of interpretation unwarrantably suggested by Sir Michael Foster to introduce confusion of ideas into a subject that has hitherto been treated in a plain and straightforward manner.

We have the honour to remain,

Your Lordship's obedient servants,

WILLIAM H. BROADBENT.	FRANCIS GOTCH.
T. LAUDER BRUNTON. (a)	G. SIMS WOODHEAD.
THOMAS BARLOW.	LEONARD HILL.
A. PEARCE GOULD.	MARY SCHARLIEB.
ANDREW CLARK.	VICTOR HORSLEY.
JOHN G. MCKENDRICK.	

(a) I sign the above protest considering that the circulation of Sir Michael Foster's memorandum would be misleading. At the same time I think that the preparation of a proper syllabus, including notice of the injurious effects of tea in excess, is a pressing need for the health teaching of elementary schools.—
LAUDER BRUNTON.

MEDICAL CONFERENCE ON THE TEACHING OF HYGIENE AND TEMPERANCE.

AN important and largely-attended conference of the medical profession in London was held on Friday, March 24th, in the Examination Hall, Victoria Embankment. Sir William Broadbent, Bart., K.C.V.O., occupied the chair, and there were present Sir Thomas Barlow, Bart., K.C.V.O., Sir Victor Horsley, F.R.S., Dr. William Collier, President of the British Medical Association, Dr. Robert Jones, Mr. McAdam Eccles, Dr. F.W. Mott, Mr. Pearce Gould, Professor Sims Woodhead, Dr. Symes Thompson, Dr. T. N. Kelynack, Dr. T. B. Hyslop, Dr. Claude Taylor, and many others.

Sir William Broadbent stated that the object of the conference was to carry a step further the movement for promoting the teaching of hygiene and temperance in the elementary schools. It was initiated by a memorial signed by nearly fifteen thousand medical practitioners, which was followed by a largely attended deputation to Lord Londonderry. His lordship expressed sympathy with the objects of the movement, but pointed out that the teachers in elementary schools were not as yet qualified to give instruction in hygiene. The training of teachers and the provision of suitable books were therefore the first questions to be considered. Of the necessity for the inclusion of hygiene and temperance in the subjects to be taught in schools there could be no doubt. The State has undertaken the education of the children of the poorer classes and has made attendance at school compulsory. It is therefore the duty of the local educational authorities, to whom this task has been delegated, to make the education given in the schools under their control efficient, and to be efficient the education must be such as will fit the children for the places they will occupy as men and women in the social organisation. It ought to prepare them to take up work by which they may earn their living and also to influence their characters for good. If there is one thing more necessary for this end than another it is health, and with regard to this the parents of these children are for the most part at once ignorant and careless. The mind of the country just now is much occupied by the question of physical degeneration. Underlying this, and largely responsible for it, is moral deterioration. At the root of both lie ignorance and vice. It is ignorance and vice that should be combated, and this can only be done early in life.

Sir Victor Horsley dealt with the attitude of the Board of Education, and criticised adversely the memorandum which had been prepared by Sir Michael Foster, many of the statements of which were characterised as misleading and scientifically unjustifiable. It was necessary that teachers should be guided and shown how they might profitably train the children in the principles of hygiene and temperance. A suitable syllabus was being prepared by a representative committee of medical experts, and would be laid before the profession in due course.

Sir Thomas Barlow spoke on the pathological aspects of alcoholism, and in defining the present position of the medical profession in relation to alcohol claimed that it was still much overrated as a therapeutic agent, and was not to be considered a necessary article of diet in the general avocations of life.

Dr. Robert Jones, Medical Superintendent of the London County Asylum at Claybury, drew attention to the report of the Inter-departmental Committee on Physical Deterioration. Carefully prepared and weighty evidence was laid before this committee by many witnesses of the intimate relationship there was between ignorance of the laws of health and the use of alcohol and any physical deterioration there might be in existence. It was a significant fact that this relationship was so repeatedly emphasised both in the evidence and in the report itself. In the latter the paragraphs dealing with alcoholism commence: "Next to the urbanisation of the people and intimately associated with it, as the outcome of so many of the conditions it creates, the question of 'drink' occupies a prominent place among the causes of degeneration. The close connection between a craving for drink and bad housing, bad feeding, a polluted and depressing atmosphere, long hours of work in overheated and often ill-ventilated rooms, only relieved by the excitements of town life, is too self-evident to need demonstration, nor, unfortunately, is the evil more open to dispute." People who have not enough food turn to drink to satisfy their cravings—the poor often drink to get the effects of a good meal. They mistake the feeling of stimulation after alcohol for the feeling of nutrition. Alcohol has a specially harmful effect upon growing tissues, and therefore upon child-life. Alcoholic habits among women were peculiarly deleterious, for if both the father

and the mother were given to alcohol the progeny would deteriorate in every way. The committee also point out the loss to the population from the high death-rate which occurs in the infants of inebriate mothers. The association between alcoholic intemperance and tuberculosis is fully endorsed in the report. The committee used the words, and after due deliberation: "As the result of the evidence laid before them, the committee are convinced that the abuse of alcoholic stimulants is a most potent and deadly agent of physical deterioration." In the recommendations that the committee urge in fighting the battle of prophylaxis are included better housing, better food, and this properly cooked, and further regulation by the State of the liquor traffic. There are in addition some special recommendations. The committee were impressed with the conviction that beyond all expedients in mitigation of the evils they were designed to meet some educative impulse is needed which will bring home to the community at large the gravity of the issue and the extent to which it is within individual effort to promote and make effective the conclusions of expert opinion. It is suggested that this might be accomplished by the more widespread dissemination of temperance literature, and by the systematic training of teachers in the laws of health, together with rational instruction in schools, embracing, but not confined to, an explanation of the effects of alcohol on the system. It was thought Dr. Jones, for each member of the medical profession to favour and support all undertakings for the abolition of alcoholism, and thus to render, in the words of the late Dr. Parkes, "growth more perfect, decay less rapid, life more vigorous, and death more remote."

Mr. McAdam Eccles pointed out that a knowledge of the effects of alcohol in small but repeated doses was of importance to the nation. Medical practitioners had great opportunities for the dissemination of such knowledge, and it was therefore highly desirable that all medical students should receive full and sound teaching thereupon. They were certain after qualification to be constantly met with questions upon the subject of alcohol in all its sociological, physiological, and pathological bearings, and they should be ready to answer these with no uncertain sound.

Dr. William Collier, Dr. Mott, Professor Sims Woodhead, Mr. Pearce Gould, Dr. Ridge, Dr. Symes Thompson, Dr. Harford and others took part in the discussion.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, March 26th, 1905.

TREATMENT OF OZENA.

THE prognosis of ozena is not so grave as heretofore, and the treatment instituted at the outset has a chance of cutting short the affection before atrophy of the mucous membrane sets in, and at the same time the fœtid odour is removed. To succeed, two operations are necessary; remove the nasal crusts by plugs of cotton wool and wash the nasal fossæ.

M. Lyon recommends for this latter injections of a saline solution (one tablespoonful of bicarbonate of soda to the quart of tepid water or salt water [two teaspoonfuls of salt to a quart]). After several days of these injections antiseptic irrigation will be made.

Phenic acid, 1 oz.

Glycerine, 4 ozs.

Water, 16 ozs.

A tablespoonful of this mixture in a quart of water. Massei advises injection two or three times a day of a solution of resorcin (4-1,000, 5-1,000). After the injections, olive oil and menthol (1-50) are instilled into the nostrils, followed by a plug of cotton on which is a little ointment of

Iodoform, 20 grs.

Peruvian balsam, $\frac{1}{2}$ drachm.

Vaseline, 1 oz.

The general treatment consists in cod-liver oil in

cases of scrofula, iron in anæmic patients and a cure at Challes Canterets or similar sulphurous waters.

DIAGNOSIS OF HÆMORRHAGIC PLEURISY.

To recognise the hæmorrhagic nature of pleural effusion is very difficult without exploring by means of the subcutaneous syringe, for the clinical signs are very unsatisfactory; frequency of oedema of the thoracic walls, absence of pectoriloquy, of bacilli, all signs common to purulent pleurisy. An exploring puncture alone will reveal the nature of the liquid. If it be sanguinolent, the cause of the pleurisy remains to be defined. Certain causes are exceptional and will be eliminated, such as cirrhosis of the liver, articular rheumatism of a grave type, chronic nephritis, aortic aneurysms. The affections being laid aside, there remain to be considered two hypotheses. Is the pleurisy of a cancerous or of a tuberculous nature?

In hæmorrhagic pleurisy due to a neoplasm, the pain is characterised by its violence; it is lancinating with irradiation towards the neck and arm. The dyspnoea is intense and the fever high; the cough is frequent, the patient prostrated, while the lymphatic glands in the axilla and at the base of the neck are indurated.

Percussion of the thorax gives a dull, woody sound at the base of the lung, while auscultation reveals complete obscurity in the respiration, but sometimes at the apex a murmur of pulmonary congestion may be found.

When the liquid is withdrawn it rapidly returns in abundance, and will persist up to the death of the patient.

In tuberculous pleurisy, the clinical picture presents some differences. The pain in the side is not so sharp, the dyspnoea is less intense, the cough is dry and short, while the strength of the patient is better maintained. After the tapping, the liquid returns more slowly, tends to become thickened and to gradually absorb.

In aged persons hæmorrhagic pleurisy is generally due to cancer of the lung.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, March 26th, 1906.

At the Medical Society Hr. Orth discussed the MORPHOLOGY OF CANCER AND THE PARASITIC THEORY.

He said that it was a pity that theories as to etiology were brought forward in which all considerations of morphology were omitted. Under such circumstances it seemed useful to bring together the actual facts. They were the following: Cancers were malignant epitheliomata. The malignancy was characterised by the heterotopy.

The first commencement of cancer could not be seen, as in the multiplication of cells the mother cell, in dividing into daughter cells, must disappear. What was formerly looked upon as a transition from normal epithelium into cancer tissue, where the epithelial layers were thicker until they pressed upon cancerous tissue, was really the reverse process, as Ribbert had shown; the cancer developed on the adjacent epithelium.

The growth of cancer was either uni-central or multi-central; in the latter case several nodules melted together by apposition.

The cancer cell was not recognisable by itself and only when it was recognised to be heterotopic. This was easily recognisable in the alimentary canal, where the muscularis mucosæ formed a sharp margin for normal epithelium. It was more difficult in other organs; it must then be considered whether the cancer bodies contained inclusions, for example, elastic fibres, as remains of tissue destroyed by them.

The polymorpha of the cells was not typical of cancer and need not be present. The function of cancer cells was that of normal epithelium, they formed keratine, mucus and even kerato-hyaline.

According to the arrangement of the cells, cancer was divided into two types: (a) that with regular arrangement, such as adenoma malignum, and cancrioid, and (b) that with irregular arrangement of cells, cancer proper. Of the latter there were as many subdivisions

as there were kinds of epithelium. In these the stroma played a more important rôle and might require an alveolar arrangement of the cells.

The cells of metastases resembled both in kind and arrangement the primary tumours. This was evidence that neither chemical substances nor parasitic germs passed along with them. The cast off tissue, the local epithelium, behaved quite passively in the metastases, and markedly so in the liver. Here the liver cells were made use of as stroma for the cancer cells; indeed, there was a metastatic cancer without stroma, for example in the blood and lymph vessels. This showed that stroma as regarded cancer was of subordinate consideration. In discussing etiology, he started with a consideration of the metastases. The infectiousness of cancer had been decided upon by these, because other infectious diseases such as suppurations had set up other suppurations by metastasis. But that the transport of any kinds of excitors was not sufficient in cancer was shown by the fact that the cells of the metastases did not develop out of the local cells, but out of transported cells, which must have originated in the primary tumour. Pus cells originated on the spot and tubercle wherever its excitor had settled.

The attempt to transmit cancer from one subject to another did not prove its parasitical nature. They were simply successful transplantations of epithelial cells capable of growth on to another individual, just as in the case of successful transplantation of skin or mucous membrane. If an inoculation experiment was to prove anything it must produce cancer from inoculation material without cells in it. We must further be able to cultivate and breed the excitor. That this might be not a bacterium but a protozoon was not a valid objection. If we were not able to make cultures of protozoa we could at any rate inoculate anophels with blood containing protozoa, and from these again set up malaria in another individual without any element from the first individual passing into the last one. It would be required further that the cancer experimentally excited should always be of the same kind as the original, adenoma should not be set up from cancrioid and vice versa. Every growing cancer cell must contain the parasite.

From all this the speaker concluded that the parasitic theory of cancer was debatable, but that he could not recognise it so long as the postulates laid down were not fulfilled, and that the theory must first be brought into unison with ascertained morphological facts. At the meeting of the 8th inst., the subject was continued by Hr. V. Hausemann in a paper on the "Etiology of Cancer."

There were three theories as to its origin: (1) the infection theory; (2) that of heredity; (3) the traumatic theory. Much light need not be expected from collective investigation, for discoveries always came from the individual.

The speaker has for years been trying inoculation, but always without effect. Positive results had been claimed by others, but they had not stood the test of investigation. It was not enough that a tumour should develop that was like cancer in its structure—it must be really cancer. This had never been done. It had been done from one animal to another, but they must be animals of the same kind and if possible of the same race. This, however, was not the transmission of infective germs, but transplantation, as Orth had pointed out.

(To be continued.)

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, March 26th, 1906.

In the third medical division of the Krankenhaus Winterbertz has recently been using "forman," which is a compound of thymol, &c., with the ether of that name. Some of his results are remarkable instances of success. A private servant, æt. 32, who had always enjoyed good health, was brought into hospital with hoarseness, cough, &c., with great pain and high

temperature, or, in other words, suffering from acute laryngitis. Chords, larynx, and fauces were swollen, red, and tender. This mixture of formaldehyde and menthol was applied in the form of vapour. By the chemical change that takes place, chlor-methyl-menthol-ether is formed, which both disinfects and soothes, destroying the microbe and soothing the inflamed surface. One or two pastilles in boiling water suffice for the preparation of the vapour. The pain and dry feeling are rapidly relieved, probably due to the presence of the menthol, while the ether may be the cause of the cool feeling experienced after the administration of the drug. The effects of the first application are ephemeral, necessitating a repetition within a half-hour after the first, but within three days the patient will be *restitutio ad integrum*.

Another example may be given of chronic laryngitis complicated with pharyngitis. Atrophic hardening and acute recrudescence had to be overcome in this case. Four pastilles were ordered at a time, and within a week the patient was well.

In bronchitis, the vapour seems even more efficacious. A joiner, *æt.* 55, had suffered for two weeks with severe pain along the sternum, cough, and irritation of mucous membrane, with cold shivers at night. Examination revealed acute bronchitis on right side associated with tracheitis, which seemed to explain the cause of pain along the sternum. Four pastilles were used in the inhalation in this case, with fifteen drops of a 1 per cent. solution of morphia in aqua laurocerasi at bedtime to relieve the pain.

Within three days the tracheitis subsided, and in five days the patient was almost well. He has now treated forty-one cases of bronchitis in this way with the same happy result. He considers that this is the most logical treatment of bronchitis, as the disinfecting vapour easily penetrates the smaller bronchi of the lungs, destroying specific germs and soothing the mucous membrane.

MASSEURS.

There is now a strong feeling in Vienna that a society of masseurs should be registered by the Chamber of Medicine, while the medical profession question the propriety of a licensed body to practise medicine under such a cloak.

The questions are asked: Who will examine and control this body, as the members are not to be subject to the practitioner, but equal to him? Those in favour of the society contend that massage is now recognised as a curative agent in many morbid conditions of the body, and that it requires expert operators to accomplish this end. Then another question comes from the other side: Must the associates be trained by licensed masseurs or by "docents," who never practised the art of massage? Again, must the licensed masseur practise no other business but massage, or can he carry on any other trade or business at the same time? Must it be left in the hands of barbers or hotel-keepers for the convenience of their customers? With all these inquiries the members of the Kammer are unable to decide what can be done.

CARCINODERMA PIGMENTOSA.

Lang demonstrated a case at the Gesellschaft der Aerzte of cutaneous carcinoma. The patient was a male, *æt.* 52, and had been treated with the Röntgen rays since August last with apparent advantage. In the history, syphilis seems to have been acquired, but the anti-syphilitic treatment had no effect on the cutaneous disease. The face is still marked with ulceration, the right eyelid quite gone, the conjunctiva ectropic and bound down to the root of the nose and cheek by a large ulcer. Large sores were also present on the ears, throat, and lower extremities. The skin on the trunk had large dark areas about the size of the palm of the hand from which projected confluent pigmentary granules about the size of a pin's head. The histological examination of an excised portion of the skin confirmed the diagnosis of carcinoma.

The interest in this case lay in the wide area of the pigmentary anomaly combined with the atrophy and carcinomatous plaques. The destructive ulceration

and serpiginous progress of the disease, combined with chronicity, gave a gloomy aspect to the prognosis. He pointed out in the differential diagnosis its close relationship with xeroderma pigmentosum, and concluded that the proper name should be carcinoderma pigmentosum from its close relationship to the latter, although perfectly distinct in character. The prognosis is doubtful. The freedom of the lymphatic glands and the absence of any sign of metastasis after years of its existence are in favour of its benignity. The malignant features of the case are demonstrated by the absence of any drug to check its progress or relieve the morbid condition. History points to the Röntgen rays as the sovereign method of treatment, which can only partially be accepted as a remedy, seeing that it still persists in appearing in new places.

Operating Theatres.

ST. BARTHOLOMEW'S HOSPITAL.

OPERATION FOR LOOSE BODY IN THE KNEE-JOINT.—Mr. McADAM ECCLES operated on a man, a railway guard, *æt.* 45, who six months previously had struck his left knee whilst descending from his van. Since that time he had repeatedly been suddenly seized with violent pain in the joint and inability to properly extend it, with the result that he not uncommonly fell to the ground. The history was therefore a clear one of a loose body in the joint. Seeing that he complained of tenderness on the outer side of the knee in the space between the external condyle of the femur and the outer tuberosity of the head of the tibia, Mr. Eccles made a curved incision exposing this part, dividing the fibrous aponeurosis, the fatty layer and the synovial membrane. On examining the under surface of the external condyle it was immediately apparent that a portion of the articular cartilage over an area of about the size of a sixpence was wanting; the edges of the gap were sharp cut and the whole thickness of the cartilage having disappeared, the compact tissue of the articular end of the bone was in evidence. Mr. Eccles considered that it was probably a case of traumatic separation of a portion of the articular cartilage, and that the missing piece was somewhere within the synovial cavity and had been the source of inconvenience to the patient; he therefore introduced his finger and felt in the various synovial pouches, but could discover no trace of the loose cartilage. The joint was now rapidly flexed and extended, and during one of these movements the detached portion was jerked out of the wound. It was then seen to be a piece of typical articular cartilage which exactly fitted the denuded area seen on the condyle. The edges of this loose cartilaginous chip had become rounded by the repeated movements to which it had been subjected. The operation was completed by uniting the cut edges of the synovial membrane by interrupted sutures of fine silk, the edges of the aponeurosis superficial to it being approximated in a similar manner, whilst the skin and subcutaneous tissues were brought together with fine silkworm-gut stitches. Mr. Eccles said that this was an important case, as it proved conclusively to his mind that it was possible for a portion of articular cartilage to be chipped off. Exactly how this may occur he admitted was difficult to explain, but the fact that the loose body removed was flattened, whitish and of the consistency of ordinary articular cartilage, as well as fitting the pit on the external condyle, proved the source of its origin. He pointed out that the detached portion of cartilage had none of the characters, either

in shape, consistence, or appearance, of a piece from a semi-lunar cartilage, and that there was no evidence either in the cartilage or in the synovial fringes of any osteo-arthritic change. He remarked that it was of the greatest importance that there should be most careful preparation in order to obtain asepsis before operations on the knee-joint; he stated that he always occupied four days for the complete cleansing of the skin. He considered that a large synovial cavity should be dealt with practically in a manner similar to the peritoneum; hence the synovial membrane itself should be accurately sutured as one would suture the edges of a peritoneal wound by one buried layer of stitches, then the aponeurosis or fibrous tissues covering the membrane should in their turn receive another layer, just as the muscular planes of the abdominal wall, and lastly, the skin and subcutaneous tissues needed a very careful adjustment. The limb, he said, should be placed for three or four days on a back splint and swung from a cradle. The pain after such an operation was apt to be somewhat severe, but this must not be considered as a bad symptom unless the temperature should rise coincidentally.

The patient maintained a normal temperature, although he complained much of pain for two or three days, during which the joint contained an excess of fluid.

ITALIAN HOSPITAL.

OPERATION FOR APPENDICITIS.—MR. LENTHAL CHEATLE operated on a female, *æt.* 25, who had just recovered from a first attack of appendicitis. The attack was a severe one; the temperature had been normal for over a week. At the operation, after the peritoneum had been opened, the examining forefinger of the right hand penetrated into a small abscess, which easily admitted it. The pus was carefully wiped away, and the operator's hand having again been sterilised, the appendix was with difficulty found and removed. A large drainage-tube was inserted into the right iliac fossa. Mr. Cheatle said that the first attack referred to was a severe one; the patient being a lady's maid, and about to travel, therefore, on these grounds alone, the operation was advised. The case, he thought, showed what a dangerous state of things can exist in the absence of pain and temperature. No swelling could be felt, as the abdominal walls had an inch layer of fat. The abscess was, he pointed out, a small one, lying immediately outside the convexity of a curled up appendix. The question was, after opening the abscess, whether it would be wise to proceed to find and remove the appendix; in his opinion, when the abscess is small, it is wise to proceed, because the appendix in such cases is more or less easily accessible, whereas in the case of a large abscess there can be no doubt about the advisability of simply draining without making any serious attempt to seek the appendix. The abscess in the present case was encysted, and on opening it with the finger pus escaped into the general peritoneal cavity, but this, he felt sure, would not lead to any infection of that cavity because the dose of infecting micro-organisms was small and the patient's immunity must be comparatively high or the virulence of the micro-organisms low, perhaps a combination of both, as the local and general conditions of the girl were quiet. On the other hand, he said, in the case of a big abscess the dose infecting the general peritoneal cavity would be large.

The case did well, the tube being removed a week after operation.

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The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, MARCH 29, 1905.

THE MEDICAL PROFESSION UPON ALCOHOL.

ONE of the most marked characteristics of man—civilised and uncivilised—is his craving for nerve stimulants, which, it need hardly be pointed out here, is simply another name for nerve poison. In vain moralists and physicians have for ages insisted that strong wine is a mocker, and that alcohol is answerable for a large proportion of the vice, misery and premature death that fall upon mankind. The curse of intemperance, as measured by the drink bills of various nations, has never reached a higher point than that registered in recent years. For all that, it is comforting to recall the fact that probably at no time have temperance organisations been more active and universal in their field of work, and at no period in the world's history has there been more individual abstention from alcohol. The opinion of the medical profession as to the ill-effects of the excessive consumption of alcohol upon populations has been again and again emphatically expressed. Their attitude of universal condemnation was carried a step further at a conference of medical men held last week in London under the presidency of Sir William Broadbent. Going to the root of the matter, the avowed object of the conveners of the meeting was to promote the teaching of hygiene and temperance in elementary schools. The significance of the association of those three great social forces, hygiene, temperance and education, savours strongly of the modern trend of thought. Here on the threshold of the twentieth century the schoolmaster is emphatically abroad, and the laws that govern sound and profitable living are to be taught in the schoolroom. Fifty years ago there was no national schoolroom, and fifty years ago alcohol was regarded as a necessity of life by the man in the street and as an indispensable drug of omnipotent value by the physician.

Nowadays all that is changed. Alcohol is looked upon as a luxury for the healthy man and a stimulant of determinate value, useful in some forms of ill-health. On the other hand, it is recognised as the cause of a vast number of pathological disturbances, functional or organic, and as a potent factor in disease, premature senility, early death, insanity, and an innumerable array of more or less deadly maladies. As pointed out by Sir Thomas Barlow, the saving clause for the consumer of alcohol was the rate of its excretion from the body. Men who were capable of constant and adequate elimination could consume moderate quantities of alcohol daily for many years without any appreciable bad results. Indeed, it is a well-recognised fact that some individuals may live to an advanced age in spite of free indulgence in alcohol during the whole of their lifetime. Exceptional cases of that kind, however, do not establish a contrary to the general assertion that alcohol is unnecessary for the maintenance of human life at a good wholesome standard as to energy, stability, and longevity. The knowledge of these things has come slowly to medical science, but now that the lesson has been learnt, it is reassuring to find that the united voice of the leaders of the profession has been raised with the sincerity not only of conviction but also of the absolute duty of proclaiming their faith in the highways and byways of our complex civilisation.

THE TRAINING OF GIRLS.

WE have got beyond the time when the British mother strongly disapproved of their daughters being taught even the most elementary facts of physiology, on the ground that they savoured of indelicacy. Nevertheless, our educational system still rigorously excludes much information that would be gladly received by the young, and would impress upon them practical details likely to be of the greatest service to them in after life. What subject is of greater interest to young girls at all stages of their development than babies, for instance? The doll is their toy of election, simply because it approximates as nearly as may be to the latent maternal instinct. Desirous of taking advantage of this instinct Professor Pinard, the celebrated French obstetrician, has succeeded in inducing the educational authorities to consent to his delivering a series of lectures to girls drawn from the State schools, between ten and fourteen years of age, on "Puericulture," i.e., the upbringing of infants. This step constitutes a really startling innovation, and Dr. Pinard states that in thirty years' experience as lecturer he has never had a more attentive audience. He simply says to the girls, "Just suppose for a moment that your dolls are living, healthy babies, and listen to me while I tell you how these little creatures can be got to live, how they can be made and kept healthy, and so grow up strong, robust men or women." He told them how to handle the tiny babe, how to clean it, dress it, and feed it, what to do, and also what not to

do, and every ear was strained to catch his half-playful, instructive remarks. Models of the suitable garments were handed round for inspection, a real nurse with a real baby went through the various evolutions incidental to washing, drying, feeding and putting to bed. They were invited to take cognisance of the best forms of feeding bottle and cradle, and the precautions that experience has suggested to avert mishap and injury. They were initiated to the mysteries of milk sterilisation and dilution, and were even instructed how to judge of the health of the child by weight, colour of the stools, &c. The point that specially strikes one is the avidity with which the young people assimilated these practical details. They are flattered that it is thought worth while trying to interest them in a subject which, though near and dear to them, has hitherto been considered unsuitable for their years. Certainly it was a brilliant idea to turn their curiosity to an account by feeding it on legitimate pabulum, and it cannot be doubted that the profound impression made on their young minds by the course of lectures and demonstrations will bear fruit when the time comes for them to reduce the precepts to practice. The moment is opportune because, later on in girlhood, so many other subjects claim their attention that they could with difficulty be induced to lend a willing ear. It is really a touching spectacle to see a great clinical teacher, one accustomed to lay down the law in medical senates, unbend and set himself the task of instructing young girls in "matters of which they cannot afford to be ignorant." It savours of a truism to suggest that it is vastly more important to the community that a girl should learn how to handle a baby than that she should commit to memory the dates of battles in centuries long ago, yet we persist in overloading their minds with fusty historical and classical material to the exclusion of what may fairly be described as vital subjects.

CONFERENCE ON HOSPITAL ADMINISTRATION.

A CONFERENCE of great interest was that recently organised by the Hospitals Committee of the British Medical Association, with a view to eliciting the ideas of hospital managers and medical men from all over the country as to the root principles on which hospital administration should be based. Besides the members of the Hospitals Committee of the Association and members of the Council, there were present nearly fifty gentlemen representing the boards of various Metropolitan and provincial hospitals, and a large group of medical practitioners interested in the question. Eleven resolutions had been prepared for submission to the Conference, and after discussion these were put to the vote, the organisers of the meeting carefully abstaining from taking any part in the proceedings beyond explaining the scope and intention of the resolutions put forward. Only the first three

resolutions gave rise to serious discussion, the others being agreed to with striking unanimity. The first debate arose on the motion "That inability to pay for adequate treatment shall be the consideration for the admission of all patients for hospital treatment," and turned on the question whether Poor-law cases came within the purview of the framers. Everyone was practically agreed that inability to pay was the first condition of admission, but a good deal of feeling was expressed at the action of Guardians in sending pauper cases, for which they are in law responsible, into the voluntary hospitals. The right view of this matter was put by Sir Henry Burdett, who pointed out that the Guardians had no right to disembarass themselves of awkward or difficult cases, for it was their duty to provide everything necessary for the paupers under their charge. The usual practice in most hospitals is to charge the Guardians a small sum to cover the expenses of such patients as are sent to them; but, as Sir Henry Burdett indicated, this may be all very well for the hospital authorities, but it amounts to robbery of the medical officers, for whose advice and skill no fee is forthcoming, although they come to the rescue of the Guardians at a time when the resources of the parish are found to be defective. Were the voluntary hospitals to refuse Poor-law cases, it is manifest that the Guardians would have to avail themselves privately of the services of outside practitioners to supplement those of their own officers, and it goes without saying that such services should be recompensed adequately; it is not equitable that the Guardians should tax the resources of charitable institutions to make good the deficiencies in their own machinery. The resolution was finally adopted by the Conference, a rider being added that Poor-law cases were not embraced by it, and that anything done for the Poor-law authorities should be paid for by them. A longer and more ardent discussion took place on the vexed question of patients' payment. It was brought up by the second resolution—"That no charge for the treatment of any patient shall be made," and even though the question of paying-wards in hospitals was put aside for subsequent consideration, a great diversity of opinion was found to prevail. The Hon. Sydney Holland, as usual, was strongly in favour of maintaining the right to make patients pay small sums towards the cost of medicines and surgical materials, while Colonel Montefiore, of the Charity Organisation Society, was opposed to it, on the ground that these payments amounted in gross to a large sum, and that the sum is diverted from the pockets of medical men in the neighbourhood of hospitals into the coffers of the hospitals. Many other speakers dwelt on the various aspects of the question, and finally the motion was rejected by twenty-eight votes to seventeen. This decision of the meeting is highly significant, as it may be taken to express the general view of hospital managers; and difficult as the matter is, the

admission of the principle of proportionate payment is one that must gravely affect the interests of the profession. Till now various hospitals have levied small tolls on their inmates in the shape of payments for medicine, or of appeals for contributions in the out-patients' room, or of forcing patients to supply certain necessaries, such as butter and sugar, but the general feeling of the profession as a whole has been that only the poor should be admitted to hospitals, and that when there they should be looked after free of cost. On such conditions alone are the honorary services of the staff justifiable, for if the business element of payment for benefits received is admitted, surely the staff should participate in the payment, for by not doing so they are laying themselves open to the charge of under-cutting their fellows. There is much to be said both from the point of view of economy and from that of self-help in limiting the supply of medicine and dressings given to out-patients, but it is questionable whether it would not be better these to be obtained from outside private traders than by payment in the hospital. The first function of a charity is to be a charity, and as such not to limit or compete with private enterprise. The third of the resolutions discussed was one proposing to abrogate the system of subscribers' letters, for which there is nothing to be said except that it brings in money by giving subscribers a certain amount of patronage in the distribution of their favours, and human nature being what it is, the inevitable result would be that subscriptions would fall off if the latter were done away with. The general undesirability of letters was recognised by the Conference, for only four members were found to vote against the motion. The other resolutions, which it would take too much space to specify, were all adopted, and the Conference may be considered to have accomplished something towards clearing the air of the administrative fog that has always obscured the hospital question in this country.

Notes on Current Topics.

Committee on "Underfed Children."

THE President of the Board of Education, with the concurrence of the President of the Local Government Board, has appointed an Inter-departmental Committee to consider what is being done with regard to the medical inspection of children in public elementary schools, and to inquire into the question of how far meals are provided for underfed children, and how this relief can be extended without throwing any charge on the public funds. So far as the terms of reference go, there would seem to be everything to admire in such an inquiry, except that to say though children should be fed as far as possible by their parents, when the latter are absolutely unable to do so the public funds ought to supply the deficiency. Although children should be provided with food in good quantity and of good

quality by their parents, the State is certainly responsible to see that no child is starved either through the neglect or inability of the parent. But it is questionable whether the subject has not got past the stage of inquiry, and whether the time for action has not arrived. It is now something like a year since the Committee on Physical Deterioration reported that children in schools should be subjected to medical inspection, and that underfed children should be supplied with proper nourishment. It seems, therefore, rather late in the day for the matter to be referred to another committee. There is, apparently, no ambiguity in the law authorising the Guardians to provide for the welfare of those without proper means of subsistence, and it should surely devolve upon them to act in the case of half-starved children. Moreover, when parents are wilfully neglectful, the charge for their children's maintenance can be recovered from them. As the new Committee is not to suggest legislation, it is difficult to see what they can find out that is not already known. We hope now that they are appointed, their sittings will be brief and their recommendations strong and unanimous. No child in the United Kingdom need be without proper nourishment, and what is needed to prevent stunted and weakly men and women being manufactured is that the present authorities should be made to fulfil their obligations.

The Control of Proprietary Medicines.

HOWEVER much the physician may wish to avoid the use of proprietary preparations in treatment, and to make use of official remedies only, he finds it in many cases impossible or improper to limit himself in such way. And, indeed, there is no ethical reason why a physician should decline to make use of a certain preparation, when its ingredients are what he requires, merely because it is the product of a particular pharmacist whose name it bears. Unfortunately, however, for the respectable pharmacists who make known the nature of their preparations to the profession and do not advertise to the public, their preparations are in many cases not distinguished by the physician from the quack nostrums which it is his duty to ignore. To make clear this distinction, and to give the practitioner a trustworthy guide to the various legitimate proprietary preparations, the American Medical Association is about to undertake the publication of a special pharmacopœia. This volume is to contain the name and constitution of any legitimate preparations submitted to the Council on Pharmacy and Chemistry of the Association. No article is to be admitted to it which is advertised to the public, or in any way offends the ethical sensibilities of the profession. In view of the constant additions which will be required, frequent editions will be issued, and in the meantime preparations approved for admission will be listed in the columns of the *Journal of the American Medical Association*. The work, if carried out, should prove of value in these countries as well as in the States.

Cancer in the Colonies.

AN interesting Blue-Book has lately been published by the Colonial Office containing reports from our various colonies on the prevalence of cancer among the different races that constitute their populations. The central fact that stands out most prominently is the comparative rarity of cancer among natives, especially those natives that have not been brought much into contact with civilisation. Many colonies are unable to give figures, or even approximate estimations of the incidence of malignant disease, owing to the aversion of natives to surgery and *post-mortems*, without which it is needless to say but little weight can be attached to the diagnosis of internal diseases. Still the facts, such as are reported, teach some lessons of value, and the Blue-Book bears witness to the keenness of medical men in every part of the Empire to do their share in helping forward the work of the Cancer Research Committee. The African negro on the East and West Coast, as well as in the interior of the Continent, seems to enjoy almost complete immunity from malignant diseases. In British Central Africa, Gambia, East Africa, and Sierra Leone, the data that are forthcoming seem to negative the occurrence of cancer; whilst in Uganda, the Gold Coast, Lagos, and Southern Nigeria only one or two cases have been met with by the doctors practising in those unfriendly climes. On the other hand in Mauritius and the Transvaal, where there are many whites and blacks mixed up together, evidence of malignant disease in natives is forthcoming to a certain extent, though not nearly so much so as in the case of Europeans. Thus in the Transvaal hospitals for 1903, no less than 3,815 cases of malignant diseases in natives were met with, 3,663 in males and 152 in females—a remarkable inversion of the incidence in this country. This liability in males is also borne out by the figures from Ceylon, and it appears to be a point that merits close investigation. The general impression left on reading the reports is that one will have to add cancer to gin, trade-guns, and small-pox as among the "blessings" conferred upon the native by civilisation.

Bacteriology and Ophthalmic Surgery.

THE utility of systematic bacterioscopic examination of the conjunctival sac before operative interference therewith is being more and more recognised by the profession every year. There is no doubt that it is improper to perform any operation on the eyeball so long as the conjunctiva contains pathogenic bacteria. Nearly every normal conjunctival sac, moreover, contains numbers of bacteria which are at any rate facultatively pathogenic, and it is the duty of every surgeon to ensure their absence before causing any lesion which may give them access to the interior of the eye. The organisms usually present are the same as those found on the skin, though certain others seem to be peculiar to the conjunctiva. In particular, the *Streptococcus pyogenes*, if present, is likely to cause serious, and perhaps destructive

suppuration. On the other hand, the *Staphylococcus* is more likely to give rise to a diffuse conjunctivitis. Fortunately, there is rarely any difficulty in clearing the eyes of these bacteria. Antiseptic lotions are but little use, as, in order to be strong enough to exert any antiseptic action, they must be strong enough to injure the conjunctiva, and therefore they are likely to give rise to infection rather than to cause sterilisation. All that is necessary, however, is frequent rinsing with sterilised water. A few days of such treatment is usually sufficient to wash away any bacteria, unless they have actually penetrated into the tissues, and in such case it is better, if possible, to postpone operation till the eye is in a healthier condition. The application of bacteriology to ophthalmic surgery makes clear, too, the futility of treatment of an eye by fomentation. There is nothing more conducive to the growth of bacteria than moist heat, and fomentations usually have the effect of retaining septic discharges swarming with bacteria in contact with the surface of the eye.

Typhus in Aberdeen.

PROFESSOR M. HAY gave a lecture recently on the outbreak of typhus in Aberdeen, and detailed the investigations he had made to track the disease to its source. In epidemics of the more common diseases, it is notoriously difficult to ascertain whence the infection came, as there is, unfortunately, in large towns always a residuum of cases present, any one of which might have acted as the starting point; but in outbreaks of small-pox and typhus it ought not to be so hard to fix the responsibility. Still, Professor Hay, after tracing cases to a particular school, and even to a particular child, was quite at a loss to account for the manner in which this individual had contracted the disease originally, and was obliged to fall back on the *de novo* explanation as the only one that would fit in with the facts of the case. On the other hand, he was able to give valuable hints as to the manner in which the disease, once started, could be conveyed from person to person. Contact of mucous membranes, either directly or mediately by means of drinking utensils, was emphasised, but more important still was the influence of vermin. Among the staff employed in removing patients several cases of infection had occurred which he attributed to fleas, and now Professor Hay has all the men provided with close-fitting garments and top-boots. Professor Hay thought that the dangers of infection were, on the whole, exaggerated in text-books, and he held that this danger is but slight in the first eight days of the illness. Another interesting point made was that typhus in children tended to run a mild course. These observations of Professor Hay, especially those with regard to the conveyance of infection, are worthy of note. Our knowledge of typhus is principally derived from the writings of the pre-bacteriological era, when infection was more a matter of superstition

than of scientific knowledge, and there can be little doubt that were typhus again to become prevalent in this country, we should improve on the theory of emanation from the skin as the agent at work. No demonstration, of course, is possible in the absence of bacteriological knowledge of the *causa causans* of the disease, but Professor Hay's suggestions are far more in accord with modern ideas than the old theories.

Chemists and Bacteriology.

A GOOD deal of interest has been aroused among chemists by the proposal made by a writer in the columns of the *Pharmaceutical Journal* that chemists should adopt as a "side-line" the examination for medical men of pathological specimens by bacterioscopic methods. It is suggested that a qualified pharmacist would have but little trouble in fitting himself, by attending a course of practical work in a bacteriological laboratory, to conduct examinations on such specimens as blood, sputum, pus, fæces, urine. A chemist may, therefore, profitably manage a clinical research laboratory on a small scale, his material being supplied by the medical men of his neighbourhood. We are afraid that gentlemen who talk in this way know but little of the difficulties and responsibilities of the pathological expert, and it is a satisfaction to find that among the correspondents of our contemporary are some who object strongly to the proposed extension of a chemist's work. It is quite true, as one of them says, that "attendance on a course of lectures and practical work does not warrant anyone posing as a competent bacteriologist." The cursory training which their other duties would permit chemists to obtain of bacteriology is certainly not of a nature to justify such a claim. Moreover, at the present day there is little need for such clinical research laboratories being scattered far and wide, even if under proper management. There are few places which are not within sufficiently easy reach of research laboratories in one or other of the large towns, and it is always to be remembered that the smaller the laboratory the less is the experience of its director, and the less value has his opinion.

No Re-Vaccination Bill.

WE have now definite information in the reply given by Lord Kenyon to the Duke of Northumberland in the House of Lords that this Government have no intention of introducing a Re-Vaccination Bill. This being so, we may safely postpone all idea of such a Bill to "this day six months," as it is difficult to believe that any Liberal Government that may follow the present Administration would be found able and willing to do so. Lord Kenyon expresses the Government view that the practical difficulties are too great for such a Bill to pass, and that its introduction would only cause increased hostility to primary vaccination. Relying on experience, the Government hope for a continuance in the fall of small-pox in the country, and all that they are prepared to do is to countenance benignly the

practice of re-vaccination among those who are willing to avail themselves of its protection. Only a large and steady increase of small-pox will now be able to influence legislation, and we have to contemplate the interesting and maybe expensive experiment of the natural history of the disease working itself out with primary vaccination and the conscientious objector as the only disturbing factors. To the logical mind this state of things is disturbing, as the policy represents neither fish, flesh, fowl, nor good red herring. Protection from small-pox can only be obtained by vaccination and re-vaccination on the one hand, or by completely efficient isolation of cases and contacts when the disease does break out. At present neither exists completely, and the only result that we can see is that vaccination is likely to become unduly discredited from the infection of those who have been vaccinated early in life and believe themselves immune. The recent experience of Dewsbury shows how little chance the "Leicester method" has of being carried out in its entirety by those who profess opposition to vaccination.

Higher Education of Women.

A BOLD paper from the pen of Dr. Van Dyke, appearing in the *Medical Record* for February 25th, attributes much marital unhappiness and all the difficulties incidental to parturition to the higher education of women. By means of high schools, competitive examinations, and mental over-exertion, he holds that the womanhood of America is becoming not only enervated but unwilling to perform her share of the marriage contract, and unable to bring forth children in due numbers without dystocia. Her frame suffers from inadequate development, and her health from the "cramming" process prevalent in women's colleges. To these he attributes the loss, or failure to develop, of the natural sexual instinct, with all its unhappy social consequences if marriage takes place. Dr. Van Dyke writes with the freshness and breeziness of the American, and draws his contrast between the woman with her true feelings and his present-day countrywoman with hers by quoting Tannhäuser's words to Venus: "Wer dich mit Gluth in seine arme geschlossen, was Liche ist, Kennt er me allein," and comparing them with the description of an imaginary novelist: "She was pale, thin, and plain-looking, with a peevish temper caused by ill-health; but Armand loved her devotedly, passionately, although lacking youth, beauty, and of a cold nature, for great was her knowledge of Theosophy, the lore of the ancients, and the differential integral calculus." Dr. Van Dyke would make a clean sweep of all recondite learning in women, and let the sex revert to natural conditions of existence as far as may be. For he remarks, "Penelope, the faithful wife; Cornelia, the proud mother, whose children were her jewels; Thusnelda, the ideal of the ancient Germans; and St. Elizabeth, the personification of Christian faith and charity, knew

nothing of soul yearnings, telepathy, psychology, and other useless things; but possessed those womanly qualities which have sent their names down the ages, and will continue to do so, until the name of the last graduate of the woman's college shall have faded from the recollection of men for ever."

Medicine in China.

PROBABLY few medical men are aware of the enormous mass of medical literature which has been published in the Chinese tongue. The works of earliest ascertained date are one on "The Pulse" and one on "Difficult Medical Questions," both published in the third century of our era, though centuries prior to them appeared a treatise in twenty-four volumes on "Internal Diseases and the Practice of Amputations." The Chinese authors never erred on the side of brevity, and we find in the thirteenth century a work on "Diseases of Women" in twenty-four volumes. In 1340 a regular encyclopædia of medicine appeared in twenty volumes, but the greatest of all Chinese medical works is that of Chu Su, an imperial prince of the Ming Dynasty, in one hundred and sixty volumes. Among more modern works is one on "The Practice of Medicine" in ninety volumes, published in 1740. In spite of this tremendous quantity of medical literature, there is but little knowledge of any value. There is no evidence that human anatomy was ever studied by dissection, and the descriptions of the body are most fantastic. In therapeutics, drugs of proved utility are used side by side with witch-medicines and charms of all sorts. Human milk is regarded as having rejuvenating power, and is bought by old people at very high price. The history of medicine in China shows no progress, such works as we have mentioned being still authoritative.

Hospital Reform.

THE first step towards hospital reform is to obtain an admission from those responsible for the management of hospitals that the system needs improvement. From this point of view there is no doubt that the Conference held some weeks ago in the Metropolitan Asylums Board-room may be productive of good results. The admission that reform is necessary tacitly given by holding such a meeting was the most important result of the gathering, although a certain number of more or less academic resolutions were adopted, which, if they do not bring us very far, have, at least, the merit of laying down certain fundamental principles on which all may agree. It is, perhaps, well to start with statements of the obvious, from which more debatable propositions may be deduced, for otherwise it would seem hardly necessary to decide solemnly, though not without cavil, "that inability to pay for adequate treatment shall be the consideration for the admission of all patients for hospital treatment." Considerable discussion was roused by the proposal that an attempt should be made to discontinue subscribers'

letters. We thoroughly agree with Mr. Sydney Holland in his remark that "it was manifestly the right thing to do, because it was wrong that a person should have to cadge for a letter before getting relief." In our experience of hospitals where subscribers' letters are in use but not compulsory, the holders of these letters are more often than other patients unsuitable economically for charitable relief, and physically for admission to hospital. Resolutions were carried suggesting the employment in every medical charity of an almoner or other officer, whose duty it should be to make investigations into the circumstances of every applicant for relief, and insisting that evidence must be forthcoming of inability to pay for treatment. These suggestions are useful, and if loyally carried out should do much to check abuse; the mere knowledge that the applicant will have to meet inquiry of this sort will deter a certain number of the well-to-do from seeking hospital relief, while having no such effect on the deserving poor.

The China Cup of Cheeriness and Comfort.

In these versatile days it is a wonder that some great writer does not launch the "Tale of a Teapot" upon the multitudinous sea of fiction. He would find the subject full of fact, fancy, and vicissitude, interwoven and embroidered with rich tints and tracery as of an Eastern carpet. Swift's "Tale of a Tub" would pale before that of a China teapot. Not so many years ago—in the days of our grandparents, to wit—the costly brew of far Cathay was sipped daintily from tiny porcelain cups. Nowadays the man in the street quaffs the coarser decoctions of India and Ceylon from vessels that would be considered dwarf-like if they held anything less than a quarter of a pint. But your real judge of tea still lingers over his choice Pekoe and rare Souchong with a zest unknown to the haphazard consumer of mushroom crudities of Indian origin. It was the true and original China leaf that the late Sir Andrew Clarke had in mind when he advocated quickly-brewed tea as an aid to digestion. The recent war tax upon tea has drawn general attention to the different values and qualities of the leaf coming from various countries. The knowing ones, however, have all along recognised that fashion has brought the choicest teas of China within reach of the modest purse. There is no reason why in his brief sojourn upon earth a man should not take just as much care in choosing his tea as he does with his wines and spirits and tobacco.

Mr. Beit's Gift to the University of London.

THE cause of University medical teaching in London has received what must necessarily be a great impetus in the shape of a donation of £25,000 from Mr. Alfred Beit. This gift is made to the Institute of Medical Sciences Fund (University of London), in commemoration of "the great kindness of his friend, Dr. Jameson,

the Premier of Cape Colony, and of members of the Faculty of Medicine during his illness from which he has now happily recovered." Mr. Beit states specifically that he was influenced in his action by the report of the Committee appointed by King Edward's Hospital Fund upon the financial relations between the hospitals and the medical schools. It will be within the memory of most of our readers that the report in question found that while the last two years of a student's curriculum can be pursued with advantage only within the walls of a hospital, his first three years, on the other hand, can be more profitably spent in a well-appointed outside school of a university character. There can be no doubt that Mr. Beit's gift will greatly strengthen the cause of University medical education in the Metropolis.

PERSONAL.

HER MAJESTY THE QUEEN has consented to become patroness of the Ladies' Association connected with University College Hospital, London.

It is announced that the Prince and Princess of Wales will be the guests of Lord Windsor at St. Fagan's at the end of June, and that on June 28th the Prince, who is Chancellor of the University of Wales, will lay the foundation-stone of the new University College buildings in Cathays Park, Cardiff.

H.R.H. PRINCESS CHRISTIAN will lay the foundation stone of the sanatorium for consumptives at Alltymydd, near Llanybyther, on April 26th.

WE understand that Princess Christian has graciously accepted the post of president of the Royal Maternity Charity of London, rendered vacant by the death of the late Duke of Argyll.

It is announced that Princess Louise of Schleswig-Holstein will open the wards for whooping-cough at the East London Hospital for Children on April 8th.

SIR WILLIAM WHITLA made a brilliant and able chairman at the annual dinner of the Irish Medical Schools' and Graduates' Association, recently held at the Hotel Cecil, London.

DR. ARTHUR ROBERTSON CUSHNY, recently Professor of Materia Medica in the University of Michigan, has been appointed to the Chair of Pharmacology and Materia Medica at University College, London.

HIS Excellency the Lord Lieutenant of Ireland visited the 'Royal Veterinary College, Dublin, on March 16th, and was received by the President, Sir Christopher Nixon, M.D., R.U.I.

At the annual dinner of the Irish Medical Schools' and Graduates' Association the Arnott memorial medal was presented by Lady Whitla to Captain R. Thomas Campbell Mackenzie, D.S.O., R.A.M.C., for distinguished bravery in saving life at sea.

Mr. Edgar Speyer has offered a prize of £100 and a silver cup for the best essay on "The Economical Management of an Efficient Voluntary Hospital." Details can be obtained from the honorary secretaries of King Edward's Hospital Fund, Cheapside, London, E.C.

THE Right Hon. C. T. Ritchie, M.P., has intimated his willingness to become a candidate for the Lord Rectorship of Aberdeen University for another term of office.

DR. C. J. MARTIN, who is the Director of the Lister Institute, left for India on March 21st, to institute scientific inquiries concerning the plague in India. This action has been taken in accordance with communications received from the Secretary of State for India.

To commemorate the long and valuable services of the late Mr. Albert Fry to University College, Bristol, a fund has been started to raise a memorial to his memory, £2,000 being collected. To this has been added various sums from local sources, bringing the total to £3,704, with this sum the north wing of the college has now been completed, and the tower christened the Albert Fry Memorial Tower.

DR. NOEL DEAN BARDSWELL, M.D.Ed., M.R.C.P. Lond., has been appointed by the King Medical Superintendent of the King Edward VII. Sanatorium, now being erected at Midhurst,

THE late Mr. James Holmes Lucking of Streatham Hill, bequeathed some £100,000 to charities, and among the bequests are the following: £2,000 each to all the chief London hospitals, also £500 each to the Mount Vernon Consumption Hospital, the City Road Chest Hospital, and the Royal National Hospital at Ventnor.

M. LE DOCTEUR BROUSSE has been elected President of the Paris Municipal Council. He has always taken keen interest in educational matters and the movement for creating a large and more sanitary Paris by demolishing the fortifications and extending the city area.

MR. T. S. P. STRANGWAYS, M.A., St. John's College, has been appointed the first Huddersfield Lecturer in Special Pathology, the duties to commence on Lady Day, 1905, the Lectureship in the first instance to be held until Michaelmas, 1909. Mr. Strangways has been University Demonstrator in Pathology for nearly seven years at St. Bartholomew's Hospital.

AN address of congratulation was recently presented to Dr. A. T. H. Waters on the attainment of his jubilee of membership of the Liverpool Medical Institution.

LORD DERBY has given a donation of £1,000 to the Margate Royal Sea Bathing hospital.

MR. ALFRED BEIT has decided to increase his donation to the Institute of Medical Sciences Fund (University of London) from £5,000 to £25,000.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

SCOTLAND.

REFORMATORY FOR FEMALE INEBRIATES.—The Corporation of Glasgow has just issued the report for 1904, the fourth year of the existence of the Girguitte Reformatory. The home has accommodation for 58 inmates, but the average number during each of the quarters of 1904 has been only 36, and during the year the new admissions numbered ten, making a total of 88 on the register since the opening. The general health of the patients has been good, and sufficient employment, indoor and outdoor, has been found for them in connection with the working of the home. Gratuities are given to inmates on the following system: 3d. a week for good behaviour, and 3d. a week for work done; part of the money may be spent when the patient is allowed out of the home for a day, the remainder being allowed to accumulate until the expiry of the inmates' sentence, when, if she remains of good conduct, weekly payments not exceeding 5s. are made until the balance is exhausted. Excursions and home visits under the charge of an attendant are permitted, and inmates who can be trusted are allowed to go messages. Visitors and writing and receiving letters

are permitted. Nine inmates out on licence are classified as—doing well, 7; hopeful, 1; doubtful, 1. During the year three inmates absconded, two after being licensed out, and one from the home. During the year the sentences of three years' detention expired in the case of 29 inmates, and particulars of each of these are given in the report. The results are as follows: Doing well, 9; hopeful, 6; doubtful, 7; hopeless, 7. The medical officer's report is appended to the general one, the chief item of interest it contains is a note on "Special Drug Treatment":—"During the year 22 inmates received special drug treatment for inebriety. It is not, however, possible at this early date to form a decided opinion as to its success, but, as far as it can be done, observations are being taken which will be useful in subsequently determining the value of such treatment. At first several patients suffered from sickness, vomiting, diarrhoea, and bilious symptoms, but nearly all slept well and took their food with more relish after the third day. The state of their general health and mental power has improved under the treatment, which, by toning up the nervous system, may aid those who are determining to reform." This is not very convincing, nor are our anticipations of benefit enhanced by the numerous quotations from patients' letters describing in more or less graphic language the sensations which the treatment produced and the good effects which followed. Testimony of this kind is more suited to the uses of a patent medicine vendor than to a scientific study of a difficult therapeutic problem.

SCOTTISH POOR-LAW MEDICAL OFFICERS' ASSOCIATION.—The report for 1904 is favourable in that it recounts less business, and therefore fewer grievances of members, than usual. Parish Councils appear to be becoming more careful in their treatment of medical officers—probably because they are learning the difficulty of filling vacant posts. Though the Bill for a more secure tenure of office was "blocked" last session, it is understood that a new Bill has been drafted. The Report refers with satisfaction to the fact that the Local Government Board departmental inquiry substantiated all the grievances of the Poor-law medical officers, and welcomes the Board's recommendations as to tenure of office, payment for drugs, and provision of official residences; the Board has not agreed to some of the Association's claims—special fees for midwifery and fractures, uniform fee for lunacy cases, and statutory holiday. Contra-advertising in the daily and medical press has been continued; the number of vacancies has been unusually small, and in these cases the council has applied to the outgoing medical officer for full information as to the nature of the post. No new litigation has occurred during the year. All through, the report goes to show how combination and solidarity of interest are benefiting the status of the medical officers in the highlands and islands of Scotland.

BELFAST.

ACTION AGAINST DR. DARNELL, OF BANGOR.—Great satisfaction is expressed by the members of the medical profession generally at the verdict in the case of Tughan v. Darnell, which came on for hearing at the Assizes here last week, the jury having failed to agree on a former occasion. The action was brought for £250 damages for personal injuries sustained by reason of alleged negligence of the defendant. In April of last year, Dr. Darnell attended the plaintiff, who is a minor, for orchitis arising from mumps, and prescribed belladonna liniment. The boy became delirious, suffered great pain, and for a time his life was in danger. The defence was that the liniment was a right and proper form of treatment, but that it had not been used with due care, nor the directions carefully followed. Mr. O'Shaughnessy was the leading counsel for the plaintiff, and Sergeant Dodd for the defendant. A large number of medical men, including Professor Sinclair, Dr. John Campbell, Dr. McKisack, Dr. Henry O'Neill, Mr. T. S. Kirk, Dr. McQuitty, and others were examined as to the action of belladonna liniment, and their use of it in practice. Mr. Justice Wright, in

summing up, reminded the jury that the matter was a very serious one, and specially so for Dr. Darnell. The jury, after half an hour's deliberation, found for the defendant.

BELFAST OPHTHALMIC HOSPITAL.—The annual meeting of this hospital was held last week under the presidency of Mr. J. Milne Barbour, High Sheriff for co. Antrim. The medical report, read by Dr. Cecil Shaw, and spoken to by Dr. J. Walton Browne, showed steadily growing numbers in the various departments. The total number of patients during the year was 2,378, with 7,518 attendances. An appeal was made by Dr. Shaw for £50 to complete the furnishing of the operating theatre, and at the close of the meeting the sum named was promised by the chairman with a prompt generosity much appreciated by the medical staff.

ULSTER HOSPITAL FOR CHILDREN AND WOMEN.—At the annual meeting of this hospital, held last week, the medical staff reported greatly increased numbers, specially in the extern department. In the children's department 2,261 new cases were seen in the extern, and 261 admitted to the wards, and in the women's department 553 new cases were seen in the extern, and 82 cases admitted. The operations performed on children were 195, and on women 51. The maternity nurse attended 172 cases. The total number of patients to whom the hospital afforded relief during the year was 3,320, an increase of 23 per cent. over the year before. The staff appealed specially for a good maternity ward, and for an accident ward for children.

PRESENTATION TO DR. J. S. STEELE, COMBER, CO. DOWN.—On his return from a trip to Madeira, necessitated by a serious illness, Dr. Steele was last week presented by his friends and neighbours with an address of congratulation on his recovery, and a purse of one hundred sovereigns, with a pearl and gold necklet and pendant and a diamond ring for Mrs. Steele.

GINGER WINE AGAIN.—At Portrush Petty Sessions last week an hotel keeper was summoned for selling ginger wine containing 2.7 gr. of salicylic acid per pint. After several experts, including Dr. J. E. Miller, of Derry, had been heard, the magistrates dismissed the case, holding that such quantities of the drug were not injurious to health. This appears to be the reversal of a recent decision in Belfast which created much interest at the time.

Correspondence.

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

HOSPITAL REFORM.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The recent Conference convened by the British Medical Association at the Mansion House, London, has a most important bearing on the interests of the medical profession. Only one really contentious resolution was put before the meeting, and on this there was a very wide difference of opinion, resulting in the defeat of the promoters of the meeting. The resolution was: "That no charge for the treatment of any patient shall be made," but it was made clear that no reference was intended to the question of paying wards, a subject which had not as yet received the consideration of the Committee. Nevertheless, although the resolution was only intended to lay down a broad principle of hospital administration, the discussion at once showed the strong feeling among many of those present that hospitals could not afford to lose the income accruing from the contributions from patients. The false economy of this argument should be obvious to all. Patients able to contribute for hospital treatment are unsuitable for it, as was admitted in the first resolution, unanimously passed, and therefore they should be refused. As the amount they contribute rarely refunds the hospital for its expenditure in their case, the hospital saves by refusing to treat them. On the other hand, if they overpay

the hospital for the services rendered, the scandal occurs of a hospital running a medical practice for gain in opposition to the unfortunate medical men who live in the neighbourhood. This question of payment by hospital patients is, we believe, the crucial point of the whole matter, and although it is well that other general principles should be agreed on, until this is settled we can expect little in the way of reform.

It is to be hoped, sir, now that the subject of hospital reform is fairly launched, that the medical practitioner of the United Kingdom will speak out boldly and see that this evil thing is scotched now and for ever. It is in the power of medical men, if they will but put their shoulder to the wheel.

I am, Sir, yours truly,

A MUCH-TRIED "G. P."

Bath, March 25th, 1905.

THE COST PER BED AT HOSPITALS IN DUBLIN.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—If the figures supplied to the Dublin Public Health Committee be correct, the cost per bed of the various hospitals in Dublin appears to be not merely a fraction of the cost in London, but less than Aberdeen or Dundee. The hospitals concerned are those which receive grants from the Corporation, as the Mater, Meath, Mercer's, Vincent's, Coombe, Children's, Rotunda, &c., and the cost for maintenance and medicines varies from £16 to £31 per bed per annum. When the cost of rent, service, and establishment charges is added, the amount is increased to about £37 to £48 per bed, or where interest on building fund or secretarial expenses have to be provided for, from £49 to £80. The cost of patients at the Louth Union Infirmary was carefully gone into a few months ago, and the cost, inclusive of every charge, was found to be £31 per bed per annum. I think that this compares favourably with any union infirmary in Britain. Nobody ever thinks of crediting Dublin with the reputation of doing things economically, but the fact remains that the record for hospital expenditure is almost uniquely low. The explanation simply is that much work is done voluntarily here which is well paid for in other cities.

am, Sir, yours truly,

J. C. McWALTER, M.D. BRUX., D.P.H.

Literature.

PUBLIC HEALTH AND PREVENTIVE MEDICINE. (a)

THOUGH primarily intended for those studying for the purpose of obtaining registrable qualifications in public health, this book should appeal to all interested in sanitary problems. The book is divided into sections dealing with Medicine, General Sanitation, Sanitary Engineering and Building Construction, Vital Statistics, Sanitary Administration and Sanitary Law. The authors decided to exclude what would have been a very lengthy bibliography in an endeavour to condense the work, and for a similar reason they do not attempt to deal fully with laboratory work, but the *rationale* of the various processes is given. No trouble has apparently been spared to make this volume acceptable to the class of students it caters for, and this is very well shown by the long list of men, authorities of repute who have helped the production of the work with advice, &c.

The work required from public health candidates is so varied and their tuition in the various subjects needs to be so thorough, that it must be a task of no slight magnitude to write a book covering all the subjects in a satisfactory way. Numerous works professing to deal

(a) "Public Health and Preventive Medicine." By C. J. Lewis, M.D., D.Sc. (Public Health) Edin., F.R.C.P. Edin., M.R.O.S. Eng. Lecturer on Public Health, Medical College for Women, Edinburgh; and Andrew Balfour, M.D., B.Sc. (Public Health), Edin., D.P.H. Camb. Pp. 688 and xxiii, with four appendices, 6 coloured plates, 5 plans and 189 illustrations. Edinburgh: William Green and Sons.

with all the subjects, but grievously neglecting those concerning which the authors do not feel themselves competent to write, testify to the difficulty of producing such a work. Whether it is better to treat of all the sections in one bulky volume, like that under consideration, or to have separate books, each to deal thoroughly with the work within its province, is a matter of opinion—personally, we incline to the latter method for more reasons than one, but to those who prefer the former we heartily commend this book.

Naturally the part of the book a reviewer usually looks at first are the coloured plates. Where such luxuries are included in a volume, it is often very good evidence of the grip the author has of his subject, as an author would sooner go without a picture that gave a misleading impression of what he was trying to explain than include such a one in his book. We are sorry to say that we have seen coloured plates which absolutely contradicted the letterpress, and it is not an uncommon thing, in medical works particularly, to find that less care seems to have been bestowed on the coloured pictures than on the woodcuts. In this volume, we find six plates, each containing six figures, and very beautiful figures they are. The lay person might consider the colours too brilliant to be true, and doubtless an artist's taste would be offended at some of the mixtures of colours, but to the bacteriologist (the plates deal with bacteria, malarial parasites, anopheles and culex pipiens) who knows the beautiful slides that can be produced by an experienced man, these plates will be very welcome, as both the outline and the colouring are very true, and this production has very obviously been carefully supervised. It appears to us that in one or two instances the magnification is slightly wrong, but it is possible that the cultures from which the original were taken may be the cause in these cases—being obviously carefully selected specimens. The illustrations in the text are, in the case of those illustrating the section on parasitic diseases, very fine and give a very good idea of the macroscopic or microscopic, as the case may be, appearance of the parasites; similarly the section on Food is very well illustrated. The picture of chicory might be clearer, the grains of wheat should be rounder and the hairs on the tea leaf should not have been omitted. The sections mentioned, Food and Medicine, are both written in a concise and systematic way, and appear on the whole to be very satisfactory. There are, however, one or two points on which our experience is not in accord with that of the authors, or where we think greater clearness would not have been superfluous. The student should be taught the necessity for careful work, and, for this reason, he should be directed to take specific gravities at 15.5° C., and not at 15° C. In applying Reinsch's test for arsenic, the beer should first be acidulated. The book contains the following extraordinary statement: "Chicory . . . can hardly be considered an adulteration (of coffee) unless its presence is not declared by the vendor. Its addition is not illegal and there is often 30 per cent. of it present in the mixture."

What would irritate some people is the way in which the authors patronise truisms, both English and Scotch. But this, of course, is a matter of taste. Tennyson and Robert Louis Stevenson are likewise called in to assist in the elaboration of the volume, and such, although also a matter of taste, may be objectionable to those who like neither poet. These are, of course, trivialities, and cannot detract from the value of a book which under all its manifold headings plainly displays the capability of the authors to write such a work. The sanitary portion is well written and well illustrated, that portion devoted to the disposal of sewage alone occupying thirty-eight pages. Hospitals, sanatoria, &c., are treated of and illustrated, vital statistics are made as interesting as such a subject can well be made, and last, but by no means least, sanitary administration and sanitary law are dealt with.

Cambridge University D.P.H. Examination.

THE examination in Sanitary Science commences on Monday, April 3rd.

CARRUTHERS' URINE EXAMINATION. (a)

THE basis of this book was a series of lectures on urine examination given to nurses at the Glasgow Fever Hospital by the author. It conducts the student systematically over the ordinary routine methods employed in the examination of the urine. Every statement made is thoroughly accurate, but the book strikes us as being much too elementary in character for the needs of medical practice. For junior students and nurses, however, this little work will prove extremely serviceable. It certainly will help to clear up many of the difficulties which usually beset the beginner in the analysis of urine. We accordingly recommend it to those who are beginning the study of clinical medicine as well as to hospital nurses, for whom it has been specially written.

Laboratory Notes.

PURE BRANDY.

THE question of pure brandy being now very much in the foreground, we have recently re-analysed some of the leading brands recognised by the medical profession, which we examined some years ago, with the following results:—

HENNESSY'S BRANDY.

Purchased samples of this well-known brand yielded the following results:—

	Hennessy's 3 Star.	Hennessy's 1 Star.
Total solids (grms. per 100 c.c.,	0.69	0.61
Ethers (parts per 100,000 of absolute alcohol)	106.7	95.2
Furfural (parts per 100,000 of absolute alcohol)	2.2	2.2
Aldehydes (parts per 100,000 of absolute alcohol)	16.0	10.6
Volatile acidity (parts per 100,000, as acetic acid)	29.7	23.8
Fixed acidity (parts per 100,000, as tartaric acid)	17.3	9.9
Absolute alcohol (by vol. per cent.)	46.1	47.1

MARTELL'S BRANDY.

From purchased samples of this well-known brand we have obtained the following results:—

	Martell's 3 Star.	Martell's 1 Star.
Total Solids (grms. per 100 c.c.)	0.67	0.63
Ethers (parts per 100,000 of absolute alcohol)	113.0	101.9
Furfural (parts per 100,000 of absolute alcohol)	2.7	2.7
Aldehydes (parts per 100,000 of absolute alcohol)	2.1	2.1
Volatile acidity (parts per 100,000 as acetic acid)	20.0	37.0
Fixed acidity (parts per 100,000 as tartaric acid)	28.0	10.0
Absolute alcohol (by vol. per cent.)	47.5	47.5

From the above results and from the excellent flavour and aroma of these brandies, we are satisfied that they are, as the manufacturers state, prepared exclusively from the juice of the grape. The advantages of a well-matured and sound grape-brandy for medicinal purposes in accordance with official requirements of the various pharmacopœias of the world are too well understood to need further comment in a medical journal.

New Surgical Appliances.

A NEW BANDAGE MATERIAL AND LIGATURES.

MESSRS. CLARKE AND COMPANY, LIMITED, of Belfast, have sent us a specimen of a surgical bandage which is woven from very fine flax, and of linen thread woven

(a) "Urine Examination Made Easy. A Method of Examining Urine with the Common Tests Fully Described." By Thomas Carruthers, M.A., M.B., Ch.B. 1s. 6d. net. London: J. and A. Churchill. 1904.

from the same material for use as ligatures. The bandage is woven in a single piece, and presents no raw edges to fray. It is very porous and should lie in position smoothly and without discomfort to the patient. In its length it is inelastic, but in its width it is capable of stretching considerably, and this enables it more easily to be adapted to irregularities of the surface on which it lies. It is well and strongly made without being in the least clumsy, and seems to us to be most suitable for use, particularly in cases in which it is desired to wash and use again the same bandage. If it was slightly elastic in the length it would make an excellent substitute for Martin's rubber bandage, and one which, on account of its porosity, would be more pleasing to the wearer. Even as it is, it is capable of being used for this purpose.

The linen thread was sent to us in skeins and also in tiny balls, each of which contain about four feet of thread. It is spun of a uniform thickness and then coated with celluloid to make it waterproof. The sample supplied consists of four strands twisted. It is smooth, for its size extremely strong, and knots easily. We recommend it to the attention of surgeons who desire to obtain a substitute for silk.

Obituary.

DR. GARNIER, OF PARIS.

DR. GARNIER, the celebrated specialist in cases of mental derangement, died recently from an embolism of the heart. He had been entrusted with the duty of making an examination into the mental condition of the Princess Louise of Coburg.

WILLIAM HENRY PRITCHARD, M.B. EDIN.

WE regret to record the sudden death from apoplexy of Dr. Pritchard, at the early age of 31. He took his M.B. Edin. in 1896, and at the time of his death occupied the post of assistant to Dr. Williams, of Cefnybedd, and was much liked in the neighbourhood.

Medical News.

The Dublin Hospital Sunday Fund.

THE Report of the Dublin Hospital Sunday Fund, presented to the annual meeting on March 21st, showed that the amount contributed to the Fund for 1904 was £3,877 4s. 6d. Collections had been made in 273 places of worship, and a sum of £72 6s. had resulted from the receipts of the hospital football match. The total increase for the year presents an increase over that of 1903 of the sum of £72 1s. 5d. The expenses of working the fund amounted to £241 8s. 7d., or 6.21 per cent. of the sum collected. The Committee of Distribution determined to distribute the sum of £3,630 among the following fifteen participating institutions, "in consideration of subscriptions received and work done":—Sir Patrick Dun's (less £6, see contra), £337 9s. 4d.; Royal City of Dublin, £324 18s. 7d.; Steevens', £193 16s. 4d.; Meath, £334 1s. 4d.; Mercer's, £175 7s. 6d.; Drumcondra, £43 10s. 4d.; Coombe, £155 12s. 5d.; Rotunda, £303 7s. 10d.; Royal Victoria Eye and Ear Hospital, £296 7s.; Convalescent Home (Stillorgan), £209 16s. 4d.; Cork Street, £366 10s.; Adelaide (less £30 17s. 3d., see contra), £420 7s. 4d.; Monkstown, £92 17s. 9d.; Orthopaedic, £218 13s. 11d.; National Children's, £157 4s. Among the speakers at the meeting were the President of the Royal College of Physicians, Sir John W. Moore, Deputy-Surgeon-General Joynt, and the Rev. J. E. Moffatt, M.D.

The Measles Epidemic in Nottinghamshire.

At a meeting of the Health Committee of the West Bridgford Urban District Council last week it was decided to close the public schools of the parish for three weeks owing to the measles epidemic now prevalent.

Health of Aberystwith.

In his recently issued annual report the medical officer of health for Aberystwith (Dr. A. Thomas)

draws attention to the dearth of houses for working men. The water-supply is ample, the storage supply being equal to a ten months' supply, even reckoning a daily consumption of 25 gallons per head of the population. The birth-rate in 1904 was 24 per 1,000 and the death-rate 13.4.

The Birmingham Hospital Saturday Fund.

THE executive committee of the Birmingham Hospital Saturday Fund was able to report at its annual meeting that a larger sum had been subscribed during the last year than ever before in the history of the fund; the sum raised was £18,643. There was a balance of over £1,000 on the year's work. In addition to giving £10,000 yearly to the various Birmingham medical charities this excellent fund supports three convalescent homes, at which no less than 2,591 men, women, and children have resided during the year. To clear off a debt of £10,000 on one of the homes the committee has promoted an exhibition of the industrial arts of Birmingham by means of which it hopes to raise a substantial sum.

The Treatment of Sewage at Wednesbury.

A NEW system of filtration has been instituted at the sewage farm belonging to Wednesbury. The filter is made of coal, has a superficial area of 500 square yards, and is capable of dealing with 75,000 gallons per day. According to Dr. A. Bostock Hill the percentage of purification effected is probably as high as at any works under similar conditions in the country. It is stated that fish turned into the effluent are thriving in it.

"Humanised" Milk.

REVERTING to the proposed supply of "humanised" milk in Birmingham, the authorities, although recognising the advantage of the scheme carried out by the Liverpool Corporation, are of opinion that it will involve too great an expenditure of public money.

Laryngology and Otology at Medical Congress.

ON March 18th, a meeting was held at the house of Sir Felix Semon to consider the position of laryngology at the International Medical Congress. The unanimous feeling of the delegates present was in complete agreement with the resolution passed by the Laryngological Society of London on January 13th. That resolution, reaffirmed one passed in 1902 to the effect that at all international medical congresses laryngology and otology should each be assigned a full and separate section.

A Grateful Company.

THE Great Western Railway Company have sent a donation of 100 guineas in acknowledgment of services rendered by the Swansea Hospital in connection with the Loughor railway disaster.

After Six Years.

MR. RICHARD CADBURY, of Birmingham, who in 1899 died in Jerusalem, left, to be paid six years after his death, the following sums which have just become due:—The London Temperance Hospital, £10,000; Birmingham General Hospital, £5,000; Birmingham Eye Hospital, £5,000; Birmingham Ear and Throat Hospital, £2,500; Birmingham Orthopaedic Hospital, £2,500.

Indian Medical Service.

THE following revised scale of leave pay for officers of the Indian Medical Service, subject to the leave rules of 1886 for the Indian army, has been sanctioned: On appointment, £250 a year; on entering the tenth year of pension service, £300; on entering the fifteenth year of pension service, £450; on entering the twentieth year of pension service, £600; on entering the twenty fifth year of pension service, £700.

A DISCUSSION on Isolation Hospitals will be opened by Dr. D. S. Davies, M.O.H., and Mr. T. H. Yabbicom, City Engineer and Surveyor of Bristol. The sessional meeting of the Royal Sanitary Institute will be held at Bristol on April 8th, at 11 a.m.

Notices to Correspondents, Short Letters, &c.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive Signature or Initial*, and avoid the practice of signing themselves "Reader," "Subscriber," "Oil 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 re-forwarding 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.

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.

A. D. F.—Laudanum is a poison included in Part II of the Poisons Schedule, but when a chemist has so labelled it he has complied with all the legal requirements. A chemist is, unfortunately perhaps, bound to supply either laudanum or morphine if a prescription be produced. The repeating of prescriptions by chemists is a matter which calls for reform.

BLOODLESS SURGERY.

To the Editor, MEDICAL PRESS AND CIRCULAR.

Sir—I fail to see the justice of your severe observations on Mr. Frank Matthews, M.B.C.V.S. and his bloodless surgery. Judging from his qualifications, who could be better fitted to treat donkeys and geese?
Yours—Lorenzo de Medicis.

RESEARCH.—That hypnotism played a part in cures wrought by the priests at Epidaurus is a matter of conjecture, but evidently nothing was left undone to create an atmosphere of suggestibility.

MEDICAL ADVERTISING OR WHAT?

To the Editor of the M.P. & C.

Sir—If there are any members of the profession who are *sensu peccati et sensu prope*, Dr. Hale White and Mr. T. Charles Symonds must be numbered among them, and if their names have been published in the Daily Press, as "An Old-fashioned Practitioner," points out in an equivocal fashion, no one who is acquainted with their blameless professional careers will for a moment believe that the publication was not extremely distasteful to them. I am yours, &c.,
H. S.

DR. F. (Leloster).—Mesotan, which is the methoxymethylester of Salicylic acid, has been successfully used in the treatment of acute rheumatism. It is chemically related to, but has not the penetrating odour of winter green.

A WEIGHTY ARGUMENT.

"Everything comes to him who waits," 'tis said,
False teeth, ear trumpets and a shiny head,
You fancy you'll escape, don't be deluded,
These are a few of what you'll have included.—A.D.

MEDICO-LEGAL.—The method of Wasserman and Schutze for the identification of the origin of blood stains is the most conclusive.

THE LOCKED CARBOLIC ACID BOTTLE.

Messrs. Thomas Christy and Co., have written us regarding the invention of the Patent Locked Bottle Co., and claiming that our criticism in last issue might give rise to misapprehension, although we think that hardly likely. They claim that the lock works automatically. This is so, if by such an expression it is understood that the locking is mechanically self-acting. The locked stopper can only be opened by inserting and turning the key which of course may be kept on a bunch or in some safe and guarded place. The invention is an ingenious contrivance for overcoming human negligence.

OTOLOGIST.—Prof. E. A. Fay, examining the records of 4,500 marriages where either or both persons were deaf, found that nearly 9 per cent. of the offspring were so affected.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MARCH 29th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. J. Smith: Clinique. (Surgical.) 5.15 p.m. Mr. W. E. Miles: Rectal Diseases.

CHILDHOOD SOCIETY AND THE BRITISH CHILD STUDY ASSOCIATION (Parkes Museum, Margaret Street, W.).—8 p.m. Discussion on Provision made under the Elementary Education Act, 1899, for Training of Defective Children (opened by Dr. F. Beach, Dr. G. E. Shuttleworth, Mrs. D. Berry, M.D., and E. M. Burgwin). (Arranged by the Childhood Society.)

NEUROLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos

Street, Cavendish Square, W.).—8.30 p.m. Clinical Evening. Cases in attendance at 8 p.m.

THURSDAY, MARCH 30th.

ROYAL COLLEGE OF PHYSICIANS OF LONDON (Fell Hall East).—p.m. Dr. W. H. Allchin: Some Aspects of Malnutrition. (Luncheon Lecture.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Dr. D. Grant: Some Important Types of Deafness.

FRIDAY, MARCH 31st.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. S. Stevenson: Clinique. (Eye.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Lecture-Demonstration:—Mr. A. de Frederville: Anesthetics.

TUESDAY, APRIL 4th.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Dr. Butler-Hogan: Infectious Diseases from a Pathological and Etiological Standpoint.

Vacancies.

East London Hospital for Children and Dispensary for Women Shadwell, E.—Medical Officer for the Casualty Department. Salary £100 per annum. Luncheon provided at the hospital. Applications to Thomas Hayes, Secretary.

Eubury Hill Asylum, Birmingham.—Two Junior Assistant Medical Officers. Salary £150 per annum, with board, lodging, and washing. Applications to the Medical Superintendent.

York Dispensary.—Resident Medical Officer. Salary £120 per annum, with board, lodging, and attendance. Applications immediately to W. Draper Esq., De Grey House, York.

Herefordshire General Hospital.—House Surgeon. Salary £100 per annum, with board, furnished apartments, and washing. Applications to W. A. W. Price, Secretary.

Birkenhead Borough Hospital.—Junior Resident House Surgeon. Salary £200 per annum and notification fees. Applications immediately to the Hon. Secretary of the Hospital.

City of London Hospital for Diseases of the Chest, Victoria Park.—Pathologist. Salary £110 per annum, Applications to Henry T. Dudley Ryder, Secretary.

Windsor and Eton Royal Dispensary and Infirmary.—House Surgeon. Salary £120 per annum, with residence, board, laundry and attendance. Applications to Geo. P. Garland, Secretary, 13 High Street, Windsor.

Appointments.

ATKINSON, JOHN PARKINSON, M.D. Glasg., L.R.C.P. Lond., L.R.C.S. Edin., Medical Officer of Health of Lynton.

BENTON, S. L., M.R.C.S., L.R.C.P. Lond., House Physician to the City of London Hospital for Diseases of the Chest, Victoria Park E.

BREWSTER, A. H., M.R.C.S., L.R.C.P. Lond., Honorary Anesthetist to the Metropolitan Throat and Ear Hospital.

BUZZARD, E. FARQUHAR, M.D. Oxon., M.B.O.P. Lond., Assistant Physician to the National Hospital for the Paralyzed and Epileptic, Queen's Square, London, W.C.

CHAPMAN, JOHN E., M.R.C.S., L.R.C.P. Lond., District Medical Officer, by the South Molton (Devon) Board of Guardians.

OLAFMAN, LUCY B., M.B. Lond., Inspector under Central Midwives Board.

COOMBS, CAREY FRANKLIN, M.D., B.S. Lond., Curator of the Museum at the Bristol General Hospital.

DICK, WILLIAM, L.R.C.P. & S. Edin., Junior House Surgeon to the General Infirmary, Macleodfield.

GRUBBAUM, O. F. F., M.D. Cantab., M.R.C.P. Lond., D.Sc., Physician to the Out-patients at the City of London Hospital for Diseases of the Chest, Victoria Park E.

HANSON, EDGAR EASTRICK, L.R.C.P. & S. Edin., a District Medical Officer by the South Molton (Devon) Board of Guardians.

HARVEY, ALFRED T., M.B. Lond., M.R.C.S., L.S.A., Medical Officer to the Children's Homes, by the Bristol Board of Guardians.

JOSEPH, H. M., M.B., Resident Medical Officer at the Hospital for Epilepsy and Paralysis, Maida Vale.

MOORE, STUART A., B.A., M.B., B.Ch. Edin., Junior House Surgeon to the Liverpool Stanley Hospital.

MORGAN, ALBERT T., M.D. Brux., L.S.A., Medical Officer to the Children's Homes by the Bristol Board of Guardians.

PURVES, W. LAIDLAW, M.D. Edin., M.R.C.S., Consulting Ophthalmic Surgeon to the Hospital for Epilepsy and Paralysis, Maida Vale.

Births.

KEWDALL.—On March 22nd, at Llys-y-Gwynt, Holyhead, the wife of George W. Kendall, B.A., M.D., of a son.

Deaths.

WARD.—On March 26th, at Baltimore, U.S.A. in his seventieth year Dr. Robert Ward, second son of the late Robert Ward, of Grosvenor Road, S.W.

The Medical Press and Circular.

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Original Communications.

CURATIVE OPERATION FOR PROCIDENTIA UTERI.

By E. HASTINGS TWEEDY,
Rotunda Hospital, Dublin.

"EVERY gynæcologist who has much hospital experience must have had cases of severe total prolapse of the uterus and vagina which are intractable to ordinary measures, cases in which no pessary can be retained, and in which the ordinary plastic and suspensory operations fail to give more than temporary relief."

So writes Dr. Christopher Martin in a communication to the British Gynæcological Society, which is fully published in the Society's *Journal* of November, 1904. In this paper he describes his very radical operation for the relief of the severest forms of this malady.

In the main it consists of the total removal of the uterus, together with the removal of the mucous membrane of the posterior and anterior vaginal wall down to the urethral orifice. The peritoneum, the stumps of the broad ligaments, and the pelvic fascia are united in separate layers with chromicised catgut, and finally the rawed vaginal surfaces are brought together by sutures.

To sum up this operation in Dr. Martin's own words, "It is a long and difficult operation, and is attended with a good deal of risk to the patients, who are as a rule elderly women and often in feeble health. There is free hæmorrhage during the course of the operation. There is considerable risk of wounding the bladder, the ureters, and the rectum. After the operation there is a good deal of shock, and shock in an old feeble woman is a serious matter. The convalescence is apt to be a tedious one, and in all my cases was complicated with deep-seated suppuration in the wound."

That such an operation should be seriously put forward as a means of relieving a condition not in itself dangerous is sufficiently surprising, but still more remarkable is the apparently favourable manner in which the communication appears to have been received by the members present at the meeting of the British Gynæcological Society.

This Society, of which I have the honour to be a member, exercises no little influence on surgical thought throughout the British Empire, not alone because of the high order of merit of the work submitted to it, but also because of its well-informed and widely circulated *Journal*. It seems

to me the plain duty of those who believe that surgery has at its disposal milder and more efficient methods in dealing with this diseased condition to raise a note of protest against Dr. Martin's operation; as an alternative, I desire to bring to your notice an operation which, on theoretical grounds at all events, I cannot but believe fulfils the requirements of a complete cure.

I do not claim originality for this procedure, but cannot at present recall the source from which I derived my knowledge of it. It probably was in an epitome of current literature in one of our many medical journals; if, therefore, my description differs in important points from its author, I urge as an excuse that the procedure had to be evolved by me from scanty material.

I have now performed the operation three times, and shall describe the technique as it was carried out on Mrs. Z., who suffered from a complete procidentia with an ovary prolapsed into the posterior vaginal wall, and extruded through the vulva. Her health was good, and she had not passed the climacteric. Some days' rest in bed combined with the usual antiseptic douches caused a cervical ulcer to rapidly heal.

The first steps of the operation consisted in the removal of a large oval flap of mucous membrane from the anterior vaginal wall, combined with a transverse incision across the cervix and just below the bladder; the latter organ was separated from the cervix and the abdomen opened between it and the uterus. Access to Douglas's *cul de sac* was next obtained by a transverse incision made in the usual manner behind the cervix. These transverse incisions were connected at their extremities by lateral incisions as in the operation for vaginal hysterectomy.

An assistant now pulled the cervix forcibly to the left side, whilst the forefinger, passed in front of, and the thumb behind, the broad ligament, were made to firmly grasp the base of this structure.

The mucous membrane of the lateral fornix was now completely detached from the base of the broad ligament by means of a scissors curved on the flat; during this the fingers protected the uterine artery and ureter from injury. A similar procedure was adopted on the corresponding side.

The bases of the broad ligaments with their ruptured fibrous bands were now brought into clear view; these robust fibrous bands, known as the ligamenta transversali colli of Mackenrodt, are composed of dense connective tissue firmly united to the supra-vaginal portion of the cervix, contain unstriped muscular fibre and constitute by far

the most important elements in keeping the uterus from prolapsing.

A curved needle carrying a fine silk suture (No. 4) was passed through the base of the broad ligament near its pelvic extremity, and the other broad ligament was treated in a similar manner. When these ligatures were brought together and loosely tied in front of the internal os, the cervix was seen to be raised upwards and backwards, slung as it were between these reunited fibres of Mackenrodt's ligaments. The loose knot was now untied so as to enable the cervix to be again brought down and permit of its easy amputation. When this was accomplished and all hæmorrhage controlled, the cervix was again pushed up and the threads attached to the broad ligaments at either side of it were tied and knotted in front of, and on a level with, the internal os. The broad ligaments were still further secured in front of the uterus by uniting them to that structure with several fine silk sutures.

The fundus of the uterus with its intervening layer of peritoneum was next secured to the anterior vaginal wall above the urethra, and the further steps of the anterior colporrhaphy completed.

All that now remained was to perform Hegar's colpo-perinæorrhaphy and to unite the vaginal skin to that of the cervical mucous membrane.

In my first and last cases I performed this operation without opening into the peritoneal cavity. I do not, however, advise the step, and believe the method above described will yield the easiest and most satisfactory results.

In conclusion, I submit that this operation, when properly performed, will prove in every sense a curative one: it rectifies the abnormal conditions answerable for the prolapse, and I sincerely trust it will obtain a fair trial before surgeons resort to what, in my opinion, is a more serious and more mutilating procedure.

THE VALUE OF UTERINE DRAINAGE IN CASES OF CHRONIC METRITIS, &c.

By ALEXANDER DUKE, M.D.

The long-continued retention in the uterine cavity of any abnormal secretion due to acute flexion, stenosis of cervical canal, invading carcinoma, &c., often gives rise to chronic metritis; in hydrosalpinx, pyosalpinx, &c. It will generally be admitted that when early symptoms of the first-named complaint are recognised, there should be no time lost in an endeavour to secure *thorough uterine cleanliness by means of an open canal*, curetting, if necessary, and subsequent drainage.

Narrow strips of antiseptic or sterilised gauze are introduced into the uterus and capillary drainage expected. This may take place so long as the gauze remains *in situ*, and when the secretions are liquid, but when viscid and thick I fail to see how any effective drainage can take place, or for sufficiently long a time to leave a lasting result. The gauze has another disadvantage: requiring frequent change, and instead of *carrying out* septic material, may carry it *in during introduction* or retard its exit altogether by acting as a plug.

In recent cases of endometritis I have found good results from rapid dilatation and the application of boric acid, after cleansing the cavity with

my blunt curette (the original form of "dredger," so-called) combined with insufflation of the vaginal walls with the powdered acid.

I believe I was one of the first—if not the first—to adopt this dry plan of treatment in cases of endometritis, for the carrying out of which I designed two useful instruments (now several years ago) made for me by Messrs. Arnold, Smithfield. The boric acid having an affinity for fluid establishes a form of uterine drainage which in a number of cases acts well, indeed, better than the gauze drain. I consider the more thorough the dilatation before curetting, the less likely is subsequent contraction to take place, more especially if no liquid caustic application, such as iodised phenol, is then subsequently applied. For the reasons given, I prefer to use the spiral wire drainage-tubes of various sizes designed by me for the cure of "stenosis" and obstructive dysmenorrhœa, and which, by affording much more room for exit of the secretions, and being in addition *self-retaining*, I have found give me excellent results (in chronic cases more especially), combined with flushing of vagina, so that I have no hesitation in recommending them in preference to the gauze drain.

I cannot help thinking that if cases of chronic endometritis were oftener treated (*directly on being recognised*) by thorough dilatation—curetting if necessary—and subsequent *drainage for sufficient time* by the spiral wire tubes, there should be no necessity for the long-continued treatment by liquid escharotics, which so often ends in failure and which sometimes leads on to tubal and ovarian disease.

Regeneration of disorganised endometrium, lymphatics, nerves, and glands does not always take place immediately after treatment. Time is an important factor, and a more extended period should be given to drainage by the wearing of the spiral wire tube, if a permanent cure is to be looked for. The assistance given to the exit of the secretions by the fact of the patient not being confined to the recumbent position, and so having the advantage of gravitation, materially aids in obtaining the desired result. Of course, when endometritis is complicated with extensive chronic metritis, or pelvic infection in addition, the disease will continue in spite of all local treatment, and hysterectomy prove the only plan of relief.

SOME ANÆSTHETIC DIFFICULTIES AND HOW TO COMBAT THEM. (a)

By ARTHUR DE PRENDERVILLE, M.R.C.S.,
L.R.C.P.

Senior Anæsthetist to the Tottenham Hospital, N.; Anæsthetist to the London Throat Hospital, W.; Lecturer on Anæsthetics, North-East London Post-Graduate College.

In the present article I propose to discuss some practical points in connection with the subject of difficult anæsthesia, or, rather perhaps, the difficulties that may and do often arise. I cannot hope in the time at my disposal to treat so large a subject exhaustively. Nevertheless, there are many points calling for serious attention which come before us constantly in daily work, and with these I shall endeavour to deal in detail, being well assured beforehand of your earnest interest, as practical men, in the points at issue.

Anæsthesia, for long years after its first inception, was treated largely as a haphazard science, charged

(a) A Paper read before the North-East London Clinical Society, at the Tottenham Hospital, on March 2nd, 1905.

with sudden and uncertain dangers, the meek handmaiden of the surgeon, who claimed its aid indeed with ardour, but who mistrusted its late results almost as much as he admired its instant triumph. To-day it stands forth a fine art. The problems which puzzled and at times even baffled original investigators have nearly all been solved by patient labourers in these later days, and now fearless and undismayed, but ever wary, we steer a safe course between the Scylla of ignorance on the one hand and the Charybdis of mere chance on the other.

So much, then, for anaesthesia in the abstract. All experience teaches that in matters surgical the best results follow a careful preparation of the patient, and this rule applies strongly in anaesthesia. It often happens, of course, that the instant demand for operation will preclude any but the most hasty attempts in this direction, but putting aside cases of extreme urgency, and unfortunately they are neither few nor infrequent, careful preparation is the keynote to easy and successful narcosis. If this would seem to be so self-evident as to be almost a hoary platitude, let me hasten to add that the rule is often carelessly observed, or perhaps, I should say, not firmly enough insisted upon. In hospitals there is always a routine method strictly adhered to, but in private, unless the medical attendant gives clear and precise directions, and sees that they are rigidly enforced, well-meaning but ignorant friends will frequently steal a march on him, and leave to the unhappy anaesthetist the final duty of wrestling, maybe, with a rebellious egg or an equally rebellious bloater.

If the operation be fixed for early morning, order the last meal to be taken at eight the previous evening. For operations that take place in the early afternoon, a preliminary abstinence of five hours will suffice. This, then, should be the rule, applicable generally for patients of good stamina and of full age. The weakly and those whose physical powers have gone down through blood-loss or prolonged illness will need a wide modification of treatment. Solids, however, should, in all circumstances, be rigidly withheld, and only that form of liquid nutriment allowed which can be easily and rapidly absorbed. As to purgation before general anaesthesia, opinions differ. It were better in many cases to rely upon an enema at the penultimate moment than to run the risk of causing intestinal disturbance by pilling the patient overnight. A costive habit will require preliminary treatment so as to cause no trouble on the eventful day itself. There is danger often in a full stomach, but not necessarily in a loaded rectum. They should both, however, be dispensed with from every point of view. Now, happily for ourselves and for our prospective patients, we have arrived at that stage of anaesthetic wisdom whereby certain definite prognostications can be indulged in as to troubles likely to occur during the narcotic period. We know, for instance, that strong jaws and good teeth, combined with muscle power above the normal, mean trouble and much resistance to the firmest efforts of the administrator; we know also that *tobacco* and *alcohol* portend storm and stress, and every imaginable artifice subconsciously displayed to delay the inevitable.

The anticipation of difficulty in any given case will obviously be a matter of moment to us, and, indeed, a great help in arranging our attack. Hence, the need of a careful if rapid survey of our patient before the induction of anaesthesia. Assuming, then, that we have a subject to deal with who approximates to one or other of the types I have spoken of, we have to decide what fundamental anaesthetic, or, alternatively, what sequence, will best do for our purpose. Shall we use chloroform alone, or ether alone, chloroform and ether together (please delete the alcohol), or, rather, shall we select a sequence—nitrous oxide-ether or ethyl chloride-ether and chloroform? The final verdict must rest with the anaesthetist, but in this matter it is well, I think, if possible, to study the individual idiosyncrasy of the operator. He, too, has grave duties to perform, and will of necessity have formed

definite opinions in regard to the suitability of certain methods of narcosis for certain special conditions. The object aimed at is the harmonious blending of many interests, and, in my view, this is often best arrived at by a happy compromise or complete unanimity as to the procedure to be observed.

And though this, in my opinion, is the plan that works best in special practice, I strongly urge upon you the adoption for general work of that fundamental anaesthetic which all experience has shown to be the safest. Ether, therefore—and preferably the nitrous oxide-ether sequence—should, in the absence of marked contra-indications, be always selected as the routine anaesthetic for the induction of general surgical narcosis. One thing, and one thing alone, has barred the way of ether, viz., the difficulty of administration; chloroform is so easy, so painfully easy, by comparison. A strip of lint, or the corner of a towel, and the patient is off—sometimes never to return! With ether there is a cumbersome cylinder to handle, and an indicator to move through half a circle, and much backing and filling and general turmoil, the while the patient splutters and coughs and tries by every device, holy and unholy, to wrestle free from bondage and impending suffocation. It is, I admit, no easy matter to become proficient in the gentle art of ether giving, but it is worth the learning and will repay those who seek for *safety*, and are well content to tread the thorny path that leads to it. But when all is said and done, anything that is worth doing at all is worth doing well, and with this aphorism in mind we may now proceed to discuss—

Difficulties to be met with in Etherisation.—Chiefly on account of the irritating nature of ether vapour, there is a marked tendency to cough during the initial stages of induction, and as a consequence, engorgement of all the structures about the head and neck may easily follow. Moreover, with continued expulsive efforts of this nature, all hopes of fully narcotising the patient would have to be abandoned, because the amount of ether absorbed would be so small as to be practically useless for our purpose. I am assuming, of course, that we are dealing with a case quite free from bronchial trouble, but possibly not free from chronic pharyngitis or some degree of nasal stenosis, the result of hypertrophic rhinitis or adenoidal growths. Ether given alone is much more liable to cause cough than if given in sequence, and hence the value of nitrous oxide to begin with. This agent paralyses reflexly the nerve endings in and about the pharynx, and paves the way for us.

One great cause of cough is, I feel sure, the admission of too much air in the early stage. My own plan is as follows: I fill my gas bag, detach it from the cylinder, and fit it to the "Clover" already charged with ether. After one or two respirations I turn on N_2O , and allow the patient to half empty the bag. The face-piece meanwhile is held firmly to the face, with ether indicator fixed at 0. With N_2O bag half emptied, I close the expiratory valve and turn on ether, slowly rotating the indicator until point 2 is reached. If possible, I exclude air entirely for one and a half minutes, then open inspiratory valve for fraction of a second, and repeat this air dosage every four or five respirations until, at the end of two or two and a half minutes, I exchange the gas bag for a small supplementary ether bag. The patient is now well dosed with gas, and slightly with ether. He is also more or less cyanosed. It is precisely at this point in my experience that cough already abolished may reappear, and this for two reasons—(1) because in the interchange of bags too much air may be admitted, and (2) because the effects of N_2O rapidly wear off and etherisation has not yet advanced far enough to control the coarse reflexes. If you turn back the indicator from 2 to 1 or $\frac{1}{2}$ or even 0, and begin *de novo*, so to speak, the chances are that your patient will get up and look at you, and thus all your previous gain will have been lost. My own plan is to keep the indicator half-way, to open the slotted valve in the angle mount of the ether bag, and to await developments. I regulate the air supply.

entirely through the slotted valve, and rarely move the face-piece at all.

Should ether vapour be ill borne at this stage, and set up cough and venous engorgement, I lessen the intake momentarily, and watch carefully for an opening to again increase the supply. But rarely do I find it necessary to lift the mask, and still more rarely, if I may say so with becoming modesty, do I cyanose the patient. Late cough is usually a sign of light narcosis and returning consciousness, and must be dealt with by pushing the anæsthetic. It need not delay us now.

Early and deep cyanosis is a difficulty to be at once dealt with and corrected; it may arise from several causes and is nearly always due to mechanical obstruction of the airway. Incurving of the lips in edentulous, spasmodic contraction of the masseters, with consequent tight clenching of full-toothed jaws, recession of a bloated tongue, with resulting closure of the glottis—these are difficulties peculiarly associated with etherisation, and may readily lead to grave danger if unrelieved.

I need say nothing of the treatment to be observed in these crises, for you know as well as I do that the fair airway must be promptly restored, and that this can only be done in one way—by promptly opening the mouth, *vi et armis* if need be, and seizing the tongue should this unruly member be at fault.

It is surprising what an ugly customer the tongue can be, and is, in some people—I mean from an anæsthetic as well as from an æsthetic standpoint. An old toper, and, I regret to add for the honour of tobacco, an old smoker, and still more the humble devotee of the delectable quid, will often present to view a lingual organ of Titanic mould clothed not, indeed, in white samite, but withal mystic, wonderful—broad-based and thickened, with root as gnarled and threatening as the head of an Irish blackthorn. Beware of such a tongue! It may give you much anxious care.

I have said nothing so far about *decubitus* in ether giving, but it is so important that I must now remedy the omission. For general anæsthesia, the supine is the classic position. True, there are many exceptions to this rule in modern operative work; with these exceptions we shall not deal now. Whatever the pose selected, there is one law that always obtains—

The head must be in the same plane as the trunk. Extreme extension and conversely extreme flexion of the head will inevitably result in blockage of the airway. Some operators in removing post-nasal growths bend the head over the end of the table, and in tracheotomy as in other conditions, extreme extension may at times be necessary.

These procedures are, however, of short duration, and are, in reality, exceptions that prove the rule. Of the two evils, flexion on to the chest is the greater, especially in fat people, and in these cases when diaphragmatic movement is limited, lifting the chin will usually suffice to restore free breathing, but it may be necessary also to push forward the whole lower jaw at the same time by pressure on the angle. This manœuvre helps to clear the base of the tongue from its temporary attachment to the pharyngeal wall. A faulty position will give rise to no end of annoyance and discomfort unless speedily rectified, and may, indeed, jeopardise the harmony of the anæsthesia altogether. Constant watchfulness and attention to minute details will alone secure in many cases a happy issue out of pain and perils.

I will say one word about the special pose of gynaecological surgery. I refer to the Trendelenberg position. You have many chances of seeing it here in full operation, and I sincerely trust you have been duly impressed with its inherent and its potential difficulties from the anæsthetic standpoint. It is sometimes almost impossible to obtain a perfectly smooth sequence unless ceaseless watch be kept over the respiration and every artifice known be used to secure a free airway. It may be and often is necessary to push the narcosis to the utmost limit of safety in order to get sufficient muscle relaxation for the surgeon, or to abolish awkward reflexes at critical moments.

You can readily see that even a temporary check to respiration may easily induce spasmodic movements of the diaphragm, and hamper the operator materially; there is an added danger in these circumstances, for any marked change in respiratory rhythm may bring about sudden engorgement of the right heart, and lead in an instant almost to the very "brink of that abysmal void whence none return." Therefore, I say, be watchful of every move in the Trendelenberg position. If with head correctly poised there is still impaired breathing, look for the cause. Do not hesitate to gag the mouth permanently, and to hold the tongue well forward, if by so doing alone you can secure an equable and safe narcosis. Above all things, regard the safety of the patient, immediate and remote, and to this end hold up the jaw throughout an operation, if no other means will serve to secure a correct position of the head. It is tiring work to attend closely to a Trendelenberg during prolonged abdominal section, but somehow time seems to fly on these occasions, and possibly one only realises the effort involved, and, parenthetically, the amount of ether absorbed, at a much later hour in the day, when under the soothing sway of the great god Nicotine, we rest at last from our labours.

Some special difficulties may arise during the administration of *chloroform*, which I will now refer to.

Of prime import is a knowledge of the factors that make for danger in chloroform narcosis. Fear, deep-seated and abiding, the result perhaps of sleepless nights and eternal introspection, or even the natural outcome of a highly-strung temperament—this is a factor that has to be reckoned with if you elect to rely on chloroform *ab initio*. I distinguish this condition from *fright*, which is, I take it, a momentary phenomenon chiefly met with in children, and then only the result of new and unlooked-for surroundings. There are people who come to the table calm, as it were, outwardly, but with fixed premonition of impending doom strong upon them. Many cases are recorded of sudden death from the mere application of a mask to the face, before even one drop of chloroform has been given. True, the heart has been diseased in 90 per cent. of these casualties, but for the remaining percentage no physical cause has been assignable. If fear, therefore, unaided, will strike so deadly a blow, we may well imagine the danger of adding fuel to fire by the exhibition of so lethal a drug as chloroform. And yet there are cases in which it will be possible to use this agent alone. How, then, are we to act?

Recent research has clearly shown that the greatest danger is to be met with at the outset of the administration; *irritation of the vagus* is peculiarly liable to follow initial absorption of chloroform vapour, and thus we may get sudden inhibition of the heart and death. *Paralyse the vagus* and all will go well. Hence it follows that extreme care must be taken to so regulate the dosage that only very dilute chloroform vapour be absorbed by the lungs, that no attempt be made to force matters unduly, and against a struggling patient that respiration and the pulse be closely watched, and as narcosis gradually deepens, that more of the anæsthetic be added, until we are satisfied insensibility of the desired quality has been reached. It is wrong physiologically and in practice to begin the attack, as is so often done, with a large overdose, in the hope of inducing rapid unconsciousness. We have changed all that, and though our methods may still be somewhat inexact, the labours of Embly and Martin have added immeasurably to our knowledge on this all-important subject. They have adorned the tale; it remains for us to point the moral.

It is not always easy to see the breathing during a chloroform sequence. Respiratory movements are slowly carried on, and there is little if any phonation to guide us. Moreover, the necessary coverings will sometimes almost entirely prevent accurate inspection of the chest walls. Means must be taken to obviate this difficulty by exposing the sternal notch, or so arranging the clothes as to give opportunity for accurate investigation. This can always be done without

creating attention or disturbing the even progress of events. Under no circumstances should more chloroform be given if, during deep narcosis, the breathing shows signs of impending arrest. The state of the pulse and pupils will be a guide as to future conduct.

It is well to remember that a very small pupil is not necessarily a sign of profound insensibility, nor is a small, rapid, irregular pulse in the absence of much blood-loss *ipso facto* a symptom of grave import. Both these phenomena, especially when associated with efforts at deglutition, may foretell vomiting; they indicate a light anaesthesia and must be met with an increase of chloroform and a deepening of narcosis, when the equilibrium will be once again restored.

Respiratory difficulties occur from time to time, independently of mechanical obstruction, and it is well to be alive to this fact. Spasmodic closure of the glottis may take place reflexly, through undue stimulation of any large sympathetic plexus, and this difficulty may occur either with ether or chloroform; in my experience it arises oftener with chloroform, and is sometimes very insidious in its onset. Curiously enough, it is often best relieved by a change of anaesthetic, after pressure on the chest walls and diaphragm has first restored the respiratory balance.

Without doubt much greater care must be observed in dealing with minor troubles under chloroform than under ether. The danger of over dosage in ether is, after all, a remote one. With chloroform, on the other hand, toxic symptoms may appear with startling suddenness, and unless a man be quick to read the danger signals and prompt in resource, he may find the thread of life snapped before him, even in the twinkling of an eye. And yet we read of men who chloroform their patients for the extraction of a simple molar or the cutting of a homely boil! Verily, they know not what they do!

Before finally leaving this subdivision, let me tell you of a very subtle danger which must be guarded against. There has been recently recorded in a coroner's court the details of a calamity which I make bold to say should not have happened. A patient under chloroform was being moved from one couch to another, the administrator holding the mask to the face throughout, when sudden death occurred, apparently at the very moment when final transference was taking place. It is no uncommon thing, of course, in busy hospital practice to anaesthetise in one room, and then to wheel the patient into the theatre; but this manœuvre is carefully accomplished on a stretcher.

With body absolutely supine, so as to interfere as little as possible with the movements of respiration, any change of posture must inevitably throw an added strain both on heart and lungs, and materially increase the danger of syncope. It is very easy under these conditions, if a saturated mask be held to the face, to give an overdose, and it cannot be too strongly insisted on that in these cases the anaesthesia should be intermitted until the patient is once more placed in position. Delay is of little consequence, and it is our duty to safeguard the life committed to our charge.

The danger of *exaggerated intake*—in other words, of *over dosage*—is often brought home to us in the anaesthetising of children. At times they struggle very violently and have to be forcibly restrained. So long as they refuse to breathe at all, there is obviously nothing to fear, but when once the relief of tears ends their short-lived rebellion, and spasmodic sobbing marks the beginning of reluctant surrender, then must we move cautiously, for respiration now proceeds apace, and if we be unmindful of this fact, we may inadvertently allow an overplus of the narcotic to be absorbed. I have personally more than once met with this incident in my own practice, and I am free to tell you that it was a very unpleasant experience, and one calculated to leave a lasting impression behind.

Another very familiar example of possible danger by over dosage may occur in attempting to push the anaesthetic after vomiting. For various reasons, vomiting will come on now and again in nervous patients, in spite of every precaution as to abstinence from food

and drink. All efforts to prevent it may end in failure.

We therefore withdraw the anaesthetic for a time, but soon return to the charge, as children rapidly recover consciousness in these cases. When, therefore, the administration is resumed, we must in the case of chloroform or C.E. begin with moderation. A fair airway now presents, and full narcosis rapidly follows a remarkably small intake. This fact should always be remembered in narcotising very young children, and weaklings generally. The susceptibility to chloroform toxics cannot in any given case be gauged with any degree of exactitude, but this we know, that the greater the lung power the greater the danger of abnormal absorption.

Unquestionably, many untoward results may be attributed to a disregard of this very obvious and well-established fact, and if we choose to ignore it, we must not be surprised to find ourselves now and then perilously near a fatality. Ether, *au contraire*, can never act with sudden malevolence in this wise, unless, indeed, we push it to a dangerous limit during arrested or embarrassed respiration.

These, then, are a few of the many important points in regard to practical anaesthesia which merit our attention, and which may very readily be brought before us in daily work. It may seem to you that there is much more to be said, and, for that matter, many an important omission from this paper. I agree, but really, the subject is so large, and in some aspects so complex, that I have felt unable on this occasion to do more than point out broad principles for general guidance, dealing only with well-known and ordinary complications, and leaving entirely without comment those still graver crises which come "like blinding fireballs hurled by giant hands" in the operative surgery of special regions. With these I shall deal on some future occasion, if the Society which has honoured me with its attention to-day so desires.

CONSTITUTIONAL TENDENCIES TO DISEASE.

By JOHN T. MACLACHLAN, M.D.,
Glasgow.

THE human frame is subject to a great variety of diseases, many of which, however, can be demonstrated, clinically, to spring from a common origin. There is, for example, tuberculosis. In early life we meet it in the form of joint affections—hip-joint disease, white swelling, tabes mesenterica, middle ear disease, with its long-continued suppuration unless measures be adopted to stay the same, enlargement of lymphatic glands, chronically enlarged tonsils, polypi in the nose, adenoid growths at the back of the throat, and other affections.

Eczema capitis (scabbed head) is chiefly, if not entirely, met with in children of a tubercular or scrofulous constitution. Later on in life, acute tonsillitis (quinsy) is common, resulting in an abscess, and this is prone to recur time and again. Still later, in early manhood, pleurisy is apt to supervene, and this same tuberculous pleurisy is liable to return again and again in the form of small localised patches, not much bigger than a square inch, over which, however, on light percussion, dullness can be detected, and the patient complains of a sharp lancinating pain at the spot. These cases are often diagnosed as pleurodynia.

The complaint lasts a few days. Adhesion no doubt takes place between the parietal and visceral layers of the pleuræ. At the *post-mortem* room such cases, I believe, furnish a large proportion of the bodies in which extensive adhesions of lungs to ribs are encountered.

Then we have phthisis pulmonalis, with its large mortality in this country. This disease seems to pick out the bloom of youth—those with delicately chiselled features, and, in my opinion, is more fatal in this type than in the lymphatic type—those with coarse features and sluggish in their movements. Again, in early life,

we meet with chronic inflammatory affections of the eyelids, scrofulous lids, which may exist through a long lifetime. I believe the disease known to oculists as phlyctenular ophthalmia is only found in patients—mostly children—of the tubercular type of constitution. Further, we have tubercular meningitis, another very fatal disease in childhood. Most of the cases of pneumonia I see occur in this same tubercular stock.

Now, all the cases of appendicitis I have seen or treated during the last fifteen years have been in tubercular subjects. In short, I look upon appendicitis as I do upon acute tonsillitis, and refer them both to a tubercular origin. The prevailing notions regarding the etiology of appendicitis, while plausible, do not fit in with the clinical facts. It is not due to constipation or eating the seeds of fruits. I have known cases of this disease in patients who never touched fruit, and whose bowels were most regular.

Enteric fever, in my opinion, has a wonderful predilection for tubercular subjects; but, of course, is not due to the tubercular bacillus. Practitioners frequently have difficulty in discriminating between enteric fever and acute tuberculosis. There is one little point I would like to mention here, and that is, I have observed the features of a patient the subject of enteric fever are preternaturally placid, while the characteristic mobility of features may be found in the tubercular affection. Pathologically, it is remarkable how the Peyer's patches in the bowel are picked out by both of those diseases, as well as their tendency to run a long course, with a hectic type of temperature, which I believe is due to the organisms of suppurative being present in both instances. Further, I may mention lupus and chilblains as part of the legacy of a tubercular inheritance. Tubercular subjects may contract malignant disease. The form it assumes in them is invariably, in my experience, sarcoma. The mental characteristics of the tubercular type are well known; vivacity of manner, mobile features, quickly-moving eyes, and an optimistic temperament. Their pulse tension is, as a rule, low, which accounts for the tendency to chilblains and lupus erythematosus. Their flesh is soft, and it is most easily bruised. Mammary abscess is very frequent in this type of constitution. The women finally become prolific mothers.

I now come to the lithæmic type of constitution; under which head I place rheumatic and gouty affections. Rheumatic fever stands alone. It is doubtless a specific disease due to living organisms. Murchison's contention was that lithæmia was due to a defective action of the liver, in which uric acid was formed in excess. I shall refer to this later. Meanwhile I find from clinical experience almost as many diseases can be grouped under the lithæmic type as could be done under the tubercular type. We have muscular rheumatism, lumbago, sciatica, neuritis of the scalp and other parts, iritis, atheroma of blood-vessels, cirrhosis of the kidneys, angina pectoris, apoplexy, eczema, stone, a tendency to parenchymatous nephritis in early life, and various neuroses, including megrim and diabetes. Malignant disease in this type assumes the scirrhus form. It is the type that furnishes, in my opinion, the majority of cases of cancer. When lithæmia is well marked there is an abnormal quantity of uric acid accumulated in the blood; the blood itself is probably altered, and the renal secretion is defective, the arteries get tense, and the patient gets moody, melancholic and introspective. I connect directly the uric acid with the high tension pulse and the melancholic mind. All this means that blood—poisoned blood—is not passing freely through the brain, and there is an anæmic state produced, comparatively speaking. If lithæmia be kept up for years, cirrhotic changes throughout the body supervene, in the kidneys, vessels and brain, with heart and brain troubles. This is the type of constitution *par excellence* for neuroses to occur from the cradle to the grave.

Rheumatic affections, such as muscular rheumatism or chronic rheumatic arthritis, have long been held to be in some way induced by exposure to the elements; sudden suppression of active sweat glands has doubt-

less some effect in determining an attack of muscular rheumatism; but the chronic forms I am inclined to attribute to long-continued acid fermentation of the starchy or saccharine elements in the dietary. Rheumatism is quite common in people who feed sparingly on nitrogenous foods, while gout is frequent in those who eat abundantly of all kinds of foods, and drink fermented liquors. As I find the treatment of chronic rheumatism and gout essentially the treatment of lithæmia, I shall not enter further into the vexed question of their etiology.

The disease known to oculists as glaucoma I classify under the lithæmic type of constitution. It resembles cirrhosis of the kidneys; and I have seen the internal administration of iodide of potash relieve and keep comfortable a case of chronic glaucoma. The condition of arterio-sclerosis described by Gull and Sutton falls under this heading. I believe Gull's description to be clinically sound, but I am not aware he connected it with lithæmia or the syphilitic cachexy. The lithæmic diathesis is essentially the catarrhal diathesis, catarrhs of the nose and throat, skin, and of the stomach being specially prone to occur and to persist. Digestion is imperfect, and there is a great tendency to fermentation of the starches and sugars in the dietary; the result of this is that acid products are formed, which probably disturb the hepatic metabolism of the nitrogenous molecules, with further vicious effects produced which are not yet fully known. Whether this theory be sound or not, I am satisfied that to begin to treat gout or rheumatism (not rheumatic fever) one of the most essential things to do is to look after the digestion of the carbohydrates.

It is curious how, in the lithæmic type, different diseases will crop up in different members of the same family. Thus I have known catarrhal or parenchymatous nephritis in a daughter, stone in the father, and mental disturbance in a son. I have also seen diabetes and stone occurring in different members of a family. Now, in diabetes, the carbohydrates are not properly digested, and a nitrogenous dietary and alkalies generally give the best results. Arsenic is known to do good, but I think its good effects are chiefly due to its antiseptic work in the stomach and bowels. Gall-stones are part of the legacy of the lithæmic inheritance. The worst forms of anæmia I have seen occur in this type of constitution. The explanation I give is the following:—The liver is, I believe with Murchison, an organ of sanguification. It has the last thing to do with preparing the nitrogenous elements for the repair of the body. When this is inadequately done there is a loss of supply. In addition the normal amount of bile not being poured into the intestines, putrefaction is set up, toxins are formed which destroy the blood globules. Highly-coloured, in reality blood-stained, urine is the result. The highly-coloured urine is a marked feature of pernicious anæmia. And the treatment of pernicious anæmia that has done good up to date is really by means of antiseptics to the stomach and bowels.

The mental characteristics of the lithæmic type are irritability, irascibility, and impulsiveness of disposition.

When the diathesis is pronounced, an unstable character is apt to result from the impoverished state of the brain. The temperament generally is the reverse of that of the tubercular diathesis. I have already mentioned that cancer is more common in this type than any other. And from what has been said above, some explanation may be gathered from the defective state of nutrition induced. When the blood is surcharged with uric acid it is natural that it will behave like a sluggish, muddy stream; the uric acid will fall where the circulation is slowest, namely, in cartilages, joints, fibrous tissues; hence arise tophi in the ears, nodules in joints.

The tubercular type of constitution is exposed to sudden attacks of illness—abscesses, pleurisies, appendicitis, peritonitis, meningitis, and I will also add pneumonia; whereas the markedly lithæmic types are more liable to chronic diseases, many with sudden and

fatal terminations, like cirrhosis of the kidneys; Writers, especially Murchison, have described the usual clinical manifestations of lithæmia—furred tongue, sallow complexion, and so on. And it should be especially noted that Murchison regarded the sallow complexion as essentially an anæmic complexion, with all that this implies. There is one sign that I have never seen described, and that is a somewhat puffy face, the lines of the features being slightly blurred, especially the line running from the inner canthus of the eye outward toward the malar eminence.

In cases of chronic gout this sagging under the eyes is most noticeable. The explanation is, I believe, as follows:—Urea is one, if not the best, diuretic known; if it be formed inadequately, the kidneys get sluggish, and the normal osmosis of the tissues is disturbed. A blue pill followed by a saline speedily removes this puffy lithæmic face, for a time, at least.

THE SYPHILITIC CONSTITUTION.

While the lithæmic and tubercular constitution can be traced back for generations, I am not aware of anyone who can say the same of the syphilitic cachexia. An attack of syphilis can be more or less successfully treated, and children free from the syphilitic taint born; but the same cannot be said of lithæmia and tuberculosis. Syphilis, as we all know, begins as a local disease in the form of a chancre, then becomes generalised throughout the system, with local manifestations in the mucous and cutaneous surfaces, particularly affecting the buccal cavity, tonsils, and throat. After a time it seems to die out of the blood, and persist in the tissues, giving rise to tertiary lesions, in the shape of gummata which break down and leave intractable punched-out ulcers in sites of the body not usually the seat of ulceration—e.g., the sternal region, or about the knees, dorsum of the feet or thumb. Gummata may develop in the brain or spinal cord, giving rise to various paralytic and other symptoms, or attack the rectum, simulating malignant disease. A common site is the testicle; they are usually painless swellings when occurring in soft tissues. Now it is during the secondary stage of syphilis, when the blood is contagious, that children are born with syphilitic taint. An idiotic child may thus be born into the world as a result of syphilis in the parent, and yet succeeding members of the family escape such a fate. Dr. Alexander Patterson, of Glasgow, has pointed out that in such idiots, the subject of inherited syphilis, the palate is deeply recessed in the shape of the letter V, the acute angle pointing, of course, in an upward direction. Pemphigus in children is another evidence of a syphilitic taint, as is also rupia. Psoriasis of the palms of the hands and feet suggest a bygone syphilitic infection. I believe many so-called intractable forms of eczema of the hands are a syphilitic inheritance and yield to antisypilitic remedies.

Persistent fissures of the tongue I have noticed in syphilitic descendants of the first degeneration, and are curable by the usual remedies. Then Hutchinson's notched teeth must not be omitted in this connection. Most writers agree that tabes dorsalis is a late manifestation of syphilis. That formidable disease, general paralysis of the insane, I believe to be also, almost invariably, the result of syphilitic infection of the system, and among other reasons for the following:—(1) It is acknowledged by nearly every writer on insanity that general paralysis attacks men of robust constitution and full of nervous energy and ambition. Now, these are the sort of men that should escape early dementia or primary disease of the brain *per se*, if such a thing can be imagined.

(2) Most writers are agreed that the disease is associated with indulgence in wine and venery. This is nearer the truth, although only half the truth, for it is the liability to contract syphilis such conduct entails that is the crucial point of the argument. Men of the world know that sexual indulgence is a matter of everyday occurrence, yet only a small proportion develop general paralysis. In country districts, where syphilis is practically absent, general paralysis is unknown.

(3) In Quaker asylums general paralysis is extremely

rare; and this clinical fact was the authority of Jonathan Hutchinson.

(4) I have seen one undoubted case of general paralysis in which the pupils were fixed, absence of knee-jerks, tremor of tongue, difficulty of enunciation, and where paresis of the zygomatic muscles had set in, recover under the persistent administration of iodide of potash in nine months.

(5) I have seen another case which finally died in an asylum lose all grandiose delusions, incessant restlessness, and become practically a sane man under iodide of potash, which had only been administered for three months, while the patient was being treated privately by me, and, to my chagrin, from domestic difficulties, the treatment could not be maintained, and a relapse took place. My experience has been so far that iodide of potash does not begin to tell much before three months; short of producing general paralysis, syphilis lying, so to speak, dormant in the system, will bring about cirrhotic changes in the vessels and atrophic kidneys.

Lately I had the opportunity of treating a retired officer in the Army whose memory was feeble and will-power reduced; specific gravity of urine 1010; arteries atheromatous. He was very unstable in his ways. There were signs pointing to an early syphilitic affection, which he admitted. Under iodide in four months this man was restored to good health, and lost his mental weakness. My belief is, that if one gets a general paralytic whose trouble is not of more than one year's standing, the persistent use of iodide of potash should be tried.

I come now to the question, what should be done for the tubercular and lithæmic types of individuals, both in the way of preventing the manifold diseases they are liable to, or curing them when they have developed?

(1) Tubercular subjects should eat freely, especially of nitrogenous foods, and malt liquors may be taken with great advantage. Beef and beer are good antidotes to consumption. The common sense rules of cleanliness, pure air, exercise in the open air, &c., should be enjoined. When some chronic form of tubercular disease has set in, cod-liver oil, iron, and stomachics, &c., may be resorted to. The iodides are useful for enlarged glands. In phthisis I have seen good results in adults from rather large doses of tincture of opium, 20 to 25 min., and dilute sulphuric acid, min. 20, three or four times a day. The opium acts by arresting the catarrhal processes. But when the lungs are riddled, such treatment is worse than useless. The suppurative infection constitutes the great obstacle in treating phthisis pulmonalis. Drainage is very imperfect, owing to the lungs hanging downwards. Great care should be taken in sterilising milk.

(2) Coming now to lithæmia, I have always found good results from $\frac{1}{4}$ to 1 grain of mercury and chalk, a little soda and pepsin given before meals. These powders disinfect the stomach and bowels, and improvement soon sets in. Indeed, I find mercury as useful in lithæmia as it is in syphilis, and should be continued off and on in small doses for considerable periods. Next to mercury, alkaline medicines are of most use. These were praised by Murchison; 20 to 30 grains of potass. bicarb. may be taken three times a day between meals; or if gravel or gouty symptoms prevail, 30 grain doses of potass. citrate have given me most satisfaction.

If the arteries are affected, 3 to 5 grains of iodide of potassium thrice daily may be taken for months, and, if need be, years, with occasional rests. The iodide is a good eliminator, reduces the blood pressure and makes the patients comfortable. It may be combined with a stimulant, such as aromatic spirit of ammonia; and if that be added to it, sweet nitre may also be put in the prescription with no fear of iodine being liberated. Aloes, cascara, iridin, and other drugs are useful to stimulate liver activity; but I prefer mercury to them all, as it is a powerful antiseptic, and clinically has given me the utmost satisfaction. Unless patients

are grossly stout, saline aperients should be avoided; they reduce the strength, but have no permanently good effects on lithæmia. The more oxygen the patient can get into his blood the better, as oxygen destroys toxins of various kinds, and doubtless burns up much of the uric acid. Thus golfing, shooting, and sea breezes are eminently beneficial to the lithæmic patient. Diet is important. In bad cases, sugars should be interdicted, starchy food reduced to a minimum, potatoes eschewed, well-toasted bread relied on. Easily-digested nitrogenous foods may be taken in fair abundance, such as poached or lightly-boiled eggs, steamed or boiled white fish, fowl or game, and mutton may be allowed. The meat foods should be cooked by boiling or grilling.

I learn from Dr. Shiels, of Glasgow, that the great advantage of grilling lies in the fact that the meat in the act of cooking is freely exposed to the oxygen of the air, which destroys the ptomaines. All stews or fried foods should be rigidly avoided. Green vegetable are perfectly safe, but it is doubtful if fruits are desirable. Clear soups, chicken, beef-tea, &c., are permissible. Mellin's food and Horlick's malted milk are safe foods and may form a little variety.

The paramount importance of taking plenty of innocent fluid into the system should not be forgotten; two or three pints of water daily is a fair allowance. In regard to alcoholic drinks, the less the better. And if any be taken, a little well-matured whisky and soda water is the safest of them all.

The prevention and treatment of syphilis is already well understood.

Transactions of Societies.

ROYAL ACADEMY OF MEDICINE IN IRELAND.
SECTION OF PATHOLOGY.
MEETING HELD FRIDAY, MARCH 17TH, 1905.

The PRESIDENT in the Chair.

CARCINOMATA.

SIR THORNLEY STOKER, President of the Academy, exhibited specimens removed by operation of:—A columnar-celled carcinoma of the uterus in a very early stage; and a columnar-celled carcinoma of rectum and sigmoid flexure, and involving the left ovary.

Dr. W. J. THOMPSON spoke, and Sir THORNLEY STOKER replied.

ACTINOMYCOSIS.

Dr. EARL made a communication on cases of human actinomycosis, and showed specimens from a case of actinomycosis of the right kidney with a metastatic abscess in the cerebrum.

Sir THORNLEY STOKER inquired whether the rarity of cultures was due to the want of a suitable medium.

Dr. CRAIG was forced, from the number of cases seen by Dr. Earl, to assume that cases of human actinomycosis were commoner than he hitherto imagined.

Mr. GUNN related particulars of cases which he had seen, and also mentioned a case where, owing to the discovery of mycelial threads in the discharge, a mistaken diagnosis of actinomycosis of the rectum was given. Later on it proved to be a carcinoma.

Dr. KIRKPATRICK mentioned a somewhat similar case occurring in the lip, where a diagnosis of actinomycosis was at first made, but subsequently this also was shown to be cancer.

Dr. EARL, in reply, stated that many of the peculiar yellow grains were made up of dead organisms, and so cultivations were not easy to obtain. He also considered the increase in the number of cases reported was due to better observation.

SARCOMA OF CONJUNCTIVA.

Mr. ARTHUR BENSON and Dr. MOONEY showed sections of a black tumour, the size of a split pea, removed from the conjunctiva of a married woman, æt. 40. It was growing by a rather small pedicle from the conjunctiva of the globe, close to the sclero-corneal margin, at the outer side of the left eye. The woman

stated that she first noticed it eleven years ago, as a very small dark reddish spot. For the past five years it had steadily but slowly grown, and some large vessels ran to its base. It was capable of being raised up with the ocular conjunctiva, and was excised with scissors, leaving what appeared to be a perfectly healthy conjunctiva below it. The origin of the growth seems to have been one of those small collections of pigment seen at times in a perfectly healthy conjunctiva. Its extremely slow growth, its low degree of malignancy, and its limitation entirely to the conjunctiva were remarkable.

Dr. MOONEY made sections of the tumour, and found that it consisted of two parts, the larger consisting of small spindle-celled pigmented sarcoma, the pigment being abundant, particularly near the periphery and round an excentrically placed non-pigmented area. This non-pigmented area, or core, which was placed towards the base of the tumour, was made up of large swollen-looking epithelioid cells, loosely arranged with plentiful intercellular substance. Many of these cells had one or two vacuoles. In none of the sections was this area in touch with the surface of the tumour, and its limits were sharply defined. In bleached sections the structure of the pigmented portion was more easily determined. Mixed with the tumour cells were large epithelioid cells, some having vacuoles, and others deep staining granules. These large cells were much more numerous where the pigment was most plentiful. Many small empty dilated spaces were scattered throughout the growth, which had very few blood-vessels. The conjunctiva covering the tumour was for the most part thickened, and at places cornified.

GANGRENOUS INTUSSUSCEPTION.

Mr. L. G. GUNN showed a beautiful specimen of the above, removed from a child.

CANCER OF THE PROSTATE.

Mr. L. G. GUNN showed sections, together with a model, of a cancer of the prostate implicating the wall of the bladder.

THE BRITISH LARYNGOLOGICAL, RHINOLOGICAL AND OTOLOGICAL ASSOCIATION.
MEETING HELD FRIDAY, MARCH 10TH, 1905, AT THE ROOMS OF THE MEDICAL SOCIETY OF LONDON.

The President, Mr. CHICHELE NOURSE, in the Chair.

CASES.

Dr. SAM LODGE exhibited a case of Excision of Superior Maxilla for Epithelioma of Antrum in a boy. He said the patient was a boy, æt. 14, who attended his out-patient department in November, 1903, complaining of nasal obstruction. The cause was thought to be due to the presence of nasal polypi. On attempting to clear the nose such fierce bleeding occurred that malignancy was suspected. The Clinical Research Association made a microscopical examination, and reported that the specimen was one of spheroidal-celled carcinoma. On March 2nd, 1904, the superior maxilla was excised. Tracheotomy had been performed a fortnight previously.

Dr. VINRACE asked whether it was suggested that a denture or mechanical appliance should be adapted for filling the gap in the palate. From the operative point of view it seemed to be a most successful case, and he presumed the nature of the disease was justified by the microscopical examination.

Mr. BARK congratulated Dr. Lodge on his successful operation. He would like the opinion of the Fellows as to whether they thought it necessary or imperative to do a preliminary tracheotomy in a case of excision of the upper jaw. In the five or six cases of the kind he had operated upon he did not do a tracheotomy, because he found there was no need for it. The other point he wanted to call attention to in reference to the case was as to the nature of it. He thought Dr. Vinrace could not have heard Dr. Wyatt Wingrave's remark on the result of his examination of the specimen. Dr. Wingrave, he understood, said it was not malignant. The one thing certain was that the tumour required

removal, and it could only be done by taking away the superior maxilla.

Dr. VINRACE said that he did not doubt the diagnosis of epithelioma, but it occurred to him it was scarcely in character with what one would expect to find clinically. His intention was to express the hope that it was fully justified by the microscopical examination. (It was shown by the microscope to be epithelioma.)

Dr. WINGRAVE said he had seen several cases of alveolar epithelioma in that situation, and they had all possessed a distinct malignancy, but that particular specimen did not conform to those which were alveolar epitheliomata. He believed the present specimen belonged to the group of endotheliomata or peritheliomata, and were of the mesoblastic type, so that they could scarcely be considered to belong to clinical malignancy.

Mr. MAYO COLLIER thought the Society was somewhat indebted to him for that case, because the one he (Mr. Collier) showed had apparently stimulated Dr. Lodge to bring his case all the way from Bradford. In his pride in showing his specimen, he (Mr. Collier) considered he had done a considerable feat in surgery, and if there was one operation which did credit to a surgeon more than another it was the removal of the upper jaw. Mr. Bark had asked whether a preliminary tracheotomy was required. He thought it would be agreed that in the hands of a competent surgeon a preliminary tracheotomy was not requisite. A skilled surgeon was capable of controlling the bleeding and removing the upper jaw without having to make any accessory wounds in any other part of the body. With regard to the extent of the operation, when looking up the literature of the subject, he found some years ago that in 70 per cent. of the cases the disease returned. In any case of malignant tumour of the upper jaw, the jaw should be removed so as to give the patient the best chance of recovery. Whether the tumour were fibroma, sarcoma or epithelioma, as much tissue as possible should be removed with it. In the case upon which he operated five years ago the woman was still alive. It was an epithelioma of the antrum which had invaded the alveoli. He believed the more fatal cases were the sarcomata. If the epithelioma were limited to the antrum well away from the post-nasal space or the inner wall of the nose, there was a much better chance of non-recurrence. It was an operation which did credit to any surgeon.

Dr. ATWOOD THORNE agreed that Dr. Lodge was to be congratulated on the result of his case, but the voice had been very bad. He did not know whether there would be any operation done to relieve that.

The PRESIDENT asked what part of the antrum the growth came from.

Dr. LODGE, in reply, said he was extremely indebted to the speakers for their remarks. The boy's parents were very poor and unable to pay for a denture. A preliminary tracheotomy was done because in the attempt to remove the supposed polypus the bleeding had been so free. He now thought that the preliminary tracheotomy was an unnecessary procedure. He was very pleased to have Dr. Wingrave's opinion of the microscopical specimen of the growth.

Dr. KELSON showed a case of Laryngeal Disease greatly improved after nasal treatment. The patient, a schoolmistress, came complaining of loss of voice, and on examination two well-marked singer's nodes were found to be present; these were removed and the voice rested, but they returned. The nose was now treated, two spurs being removed and the galvanocautery applied to the hypertrophied turbinated bodies, since which time the nodes have gradually disappeared.

Dr. KELSON also showed a case of Deformity of the Fauces. The patient is a married woman, æt. 36, who suffered at four years of age from scarlet fever, the sequelæ of which are to be seen in her right membrana tympani (perforated) and symmetrical cicatricial adhesions of the posterior pillars of the fauces to the posterior wall of the pharynx. For the last six years she

had suffered from an enlarged thyroid which is slowly increasing in size.

Dr. ATWOOD THORNE asked whether any other member had had a similar case in which the posterior part was attached to the pharyngeal wall.

Dr. VINRACE said he was about to make the same observation. It seemed to be almost a unique case of deformity of the soft palate. The adhesions to the pharynx were absolutely symmetrical. He understood that it followed scarlatina.

Dr. KELSON, in reply, said he had seen one or two somewhat similar cases following scarlet fever, but not quite so symmetrical; there was no evidence that the patient ever had syphilis.

Dr. WYATT WINGRAVE.—Case of Fixation of Left Vocal Cord in a youth, æt. 15. The patient suffered with hoarseness, but not loss of voice, for four months altogether. When he first saw the patient the larynx was somewhat injected, but on a second examination all that injection disappeared. There remained, however, a complete fixation of the left vocal cord. There was no history of any tuberculosis, either personal or family, nor of trauma, nor of fits or any neurosis. It was largely a question whether the fixation of the cord was of mechanical origin or whether it was neural. Several of his colleagues had seen it, and they were of opinion that it was a case of neurosis. But there was considerable infiltration, which completely fixed the arytenoid. In view of that he was inclined to think that there must be something at fault more than simply the innervation.

Dr. ATWOOD THORNE said it looked to him like a typical collar-stud colloid. He had seen larger specimens in South Africa and in the West Indies. St. Mary's Hospital possessed a good specimen from the Indies. The only treatment was to remove it and bring the edges together.

Dr. WINGRAVE: Case of Growth of Auricle in a female, æt. 22; duration twelve months. The story of it was that it lasted twelve months. The ears were pierced when she was fourteen years of age, that is to say, ten years ago. There was no history of an undue irritation or eczema, but she noticed that the passage of the ear-ring had become a little difficult, and that after four months she could not pass it at all. It was a solid growth suggestive of a fibroma, which was histologically like keloid.

Dr. ANDREW WYLIE: Case of Growth (Papilloma) in the Larynx, under treatment by the galvanocautery. The patient was a man, æt. 52, a foreman in a flour mill, working in a dusty atmosphere. The man consulted him last September, complaining of loss of voice and slight difficulty in respiration. For several years the patient had been troubled with hoarseness. On examination, a greyish, somewhat irregular growth, about the size of a large pea, was seen in the anterior commissure, below and between the vocal cords. No microscopical examination was made. The growth was touched six times during October with the galvanocautery (a fine point being used at an angle towards the operator). The larynx was first anaesthetised by a 20 per cent. solution of cocaine (15 minims used altogether and inserted by a laryngeal syringe 5 minims at a time). After each application of the cauterly the patient became very hoarse for a few days, but afterwards soon recovered his voice, and at the end of October the growth had disappeared. He could not continue the treatment at the end of last year as he (Dr. Wylie) was ill. The patient had just returned with the growth slightly reappearing, and he brought him to show the Society before resuming the treatment. He proposed to show the patient again after he had got the growth away.

Mr. BARK said one did not often meet with growths in the anterior commissure. Those which came under his notice had been soft fibromata, not papillomata; they were mostly of embryonic origin. He suggested to Dr. Wylie that it would be better to remove the growth by a curette or snare instead of the galvanocautery. Yet he admired the skilful way in which the

growth had been reached below the cords with galvano-cautery.

Dr. KELSON congratulated Dr. Wylie on having destroyed that portion of the growth which was producing hoarseness—viz., that lying between the vocal cords; he did not know that it was absolutely necessary to interfere with the other part, as it did not appear to be doing any harm.

Dr. WYLIE, in reply, said he could not say whether it was fibroma or papilloma, as he had not had a specimen for examination. He agreed that it might be better to curette it out, but he wished to treat it with the galvano-cautery. He practised many times before he could get his hand into the way of properly touching it. With regard to Dr. Kelson's remarks, the man could scarcely speak when he came. If it had been thoroughly cauterised he thought it would never have come back.

Dr. ABERCROMBIE: Case of Lympho-sarcoma of the Frontal Sinus. (Shown by Dr. Wylie.) Dr. Wylie said the patient was a woman, æt. 75, shown at last meeting, upon whom Dr. Abercrombie had operated Nov., 1904, and apparently cured the patient. She now returned with a large recurrence, with invasion of the disease to right nasal fossa, and therefore Dr. Abercrombie wished to show the case again. He did not contemplate any further operation.

Dr. ABERCROMBIE: Patient shown at a previous meeting on whom an operation was performed for adhesion of the soft palate to the pharyngeal wall.

Dr. WYLIE said that Dr. Abercrombie showed the case before the Society, January, 1903. He separated the soft palate, which was bound down by adhesions from the posterior pharyngeal wall, and kept it free by means of india-rubber tubes until the raw surface was healed. He wished now to show the result of his operation.

Dr. WYATT WINGRAVE: Microscopical specimens: (1) Epithelioma of Larynx from a case under the care of Dr. Lodge. Dr. Wingrave said the specimen was one which Dr. Lodge sent him for examination after operation. The interesting feature about it was that it illustrated very well indeed the extraordinary cell polymorphosis which occurs in this variety of neoplasm, together with the presence of well-defined so-called parasites. (2) Dermoid Cyst of Neck, from a case under the care of Dr. Nourse. Dr. Wingrave said it was a cyst which the President removed from a patient a short time ago, and presented all the characters of a suppurating gland. The contents consisted of squamous epithelial cells and pus cells, but no bacteria of any kind.

A discussion then took place on Dr. Sim Wallace's paper on "Nasal Obstruction and Mouth Breathing," in which Dr. Harry Campbell, Mr. Mayo Collier, Dr. H. B. Scanes Spicer, Dr. G. A. Sutherland, Dr. Wyatt Wingrave, Mr. James Wigg, Mr. E. Dennis Vinrace, and Dr. Andrew Wylie took part.

Dr. SIM WALLACE replied.

The annual dinner of the Association was held the same evening, the President in the Chair.

THE SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

MEETING HELD MARCH 17TH, 1905.

Dr. LEONARD GUTHRIE in the Chair.

Dr. O. GRUNBAUM showed a boy, æt. 9, with "Alopecia Universalis." The hair of the head came out in patches two years ago, complete baldness resulting in one year. Then the eyebrows and most of the eyelashes seemed to fade away. The nails were normal. No cause was found.

Mr. G. PERNET recommended liberal diet, tonics, thyroid extract and stimulating lotions.

Dr. R. HUTCHISON exhibited a case of "Late Rickets" in a boy, æt. 9. For some months the legs had been gradually bending. There was marked epiphyseal enlargement of the lower ends of the radius and ulna, of the knees and of the ankles, with typical

rickety curvature of the femora and tibiae. The skull, chest, and viscera showed no changes. The boy had rickets at the age of three and had never completely recovered from it.

Mr. SYDNEY STEPHENSON showed a boy, æt. 9, with "Tuberculosis of the Lachrymal Sac." Tubercle bacilli were found in scrapings from the interior of the diseased sac. There was a family history of tuberculosis. The boy had had enlarged cervical glands treated by operation, and still presented chronic ulceration of the nasal chambers, probably tuberculous.

Mr. SYDNEY STEPHENSON also showed a typical case of "Keratomalacia" in a girl, æt. 8 months. The condition was one of sloughing of the cornea in a young child suffering from marasmus. It is rare in England. It corresponds with "Hikan," an epidemic disease of Japan; with the Ophthalmia Brazilianiana of South America; and with the destructive keratitis common in Russia during the great Lenten fast. The eyes were kept shut, no discharge of muco-pus, and both corneae were converted into greyish-white sloughs.

Dr. J. CHARLTON BRISCOE showed a girl, æt. 13, with "Tremor of the Right Arm," very rapid, better felt than seen. It was absent during sleep, constant while awake, increased after exertion, and diminished after rest. The muscles of the forearm and hand were not involved. No other change in the nervous system was found. The onset was sudden, three months ago, with anorexia and lassitude.

Dr. GUTHRIE suggested that the condition was due to a mild encephalitis or thrombosis of some of the finer vessels of the cortex on the left side.

Dr. G. SUTHERLAND thought the condition "functional," a diagnosis with which Dr. Briscoe agreed.

Dr. F. PARKES WEBER showed a child, æt. 12, with jaundice and very considerable chronic enlargement of the spleen. The lymph glands were not enlarged and the blood showed nothing abnormal. The mother had had six still-born children.

Mr. J. HOWELL EVANS showed a case of "Osteoma of the Bregmatic Wormian Bone."

Mr. G. F. HETT showed a case of "Tuberculosis affecting the Lungs, Cervical Glands, and Ears."

It was discussed by Dr. Carre-Smith, Dr. G. Sutherland, Mr. Howell Evans, and others.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, April 2nd, 1905.

REGIME AND TREATMENT FOR AFFECTIONS OF THE LIVER.

THE therapeutic treatment of the various forms of liver disease is still obscure. A monograph by M. Clavand on the subject is interesting from this point of view, and merits a brief notice.

For M. Clavand *opiotherapeutic preparations* of the liver stimulate the glycogenic and bilogenic functions of the liver, and, according to MM. Spillman and Demange, cause albuminuria and urobilinuria to disappear. They are especially indicated in atrophic or hypertrophic cirrhosis. MM. Gilbert and Carnot administer by the rectum six ounces of pig's liver macerated for two hours in half a pint of warm water. The same amount might also be taken by the mouth, but to many patients the treatment is repugnant.

Moderators of the function of the liver are indicated in the treatment of hypertrophy in the first stage; they include opium, belladonna in small doses, arsenic, mercurial preparations, and especially calomel given at the dose of $\frac{1}{2}$ grain daily; iodide of potassium continued for a long time at the dose of 4 to 8 grains daily.

Hepatic stimulants are more numerous and better known. Iodide of potassium is an indirect stimulant, acting on the cardio-vascular system. Benzoate of soda is given at the dose of 4 to 6 grains a day, and is considered an excellent cholagogue by Prevost and Binet. Salicylate of soda gives very good results at the dose of 10 to 30 grains daily; its action is less energetic, but more durable than the preceding. Boldine was specially recommended by Dujardin-Beaunet

and Verne; it is given in infusion (30 grains to 5 ounces of water), taken three hours after meals. Euonymin is both a cholagogue and a laxative. M. Robin gives it in 1 grain pills associated with extract of hyosciaminus. Podophyllin is doubtful in its action, and as regards alkaline waters (Vichy, Vals), they can act either as stimulants or depressors, according to their doses and method of administration.

What should be the *regime* for hepatic patients? It is well known that albuminoid substances are, of all foods, those which possess the most stimulating action on the different functions of the liver, consequently meat of all kinds should be as much as possible eliminated from the food when the liver is affected. Vegetable albuminoids, milk, eggs, less toxic, may be allowed. It is also proved that fats in general have a baneful action on the hepatic cells, but a distinction is necessary. Vegetable oils, fresh butter, are relatively well tolerated.

Milk is the best *regime* for the liver. From the above it results that the *regime* for persons suffering from liver disease should be moderate in quantity but yet sufficient. Meat should be taken in very small quantities or not at all, but fowl and pork should be absolutely proscribed. Green vegetables, such as peas, haricots, artichokes may be allowed, but spinach, cabbage, turnips, radishes should be forbidden, as being indigestible. As drink, Vittel water, and perhaps a little white wine, not too acid. Alcohol, coffee, chocolate should be excluded.

Catarrhal icterus.—The patient will be put on milk and belladonna administered.

Ext. of belladonna, $\frac{1}{4}$ gr. ;

Excipient, q.s.

For one pill; one night and morning.

At the same time large enemata of cold water, alkalines, saline purgatives, abundant drinks will be ordered.

IN ATROPHIC CIRRHOSIS :—

Iodide of potassium, 1 dr. ;

Sulphate of strychnine, $\frac{1}{4}$ gr. ;

Water, 10 ozs.

Two tablespoonfuls daily.

Benzoate of soda, 5 gr. ;

Phosphate of soda, 10 grs. ;

Powdered jaborandi leaves, 2 grs.

For one wafer, to be taken three hours after the repast, along with a cup of infusion of boldine.

Boldine leaves, $\frac{1}{4}$ dr. ;

Water, 4 ozs.

An aloe pill every night.

HYPERTROPHIC CIRRHOSIS :—

Milk; calomel at the dose of $\frac{1}{4}$ grain daily for eight days; after which—

Arseniate of soda, 1 gr. ;

Water, 10 ozs.

A tablespoonful morning and evening.

For ascites theobromine will be given :—

Theobromine, 30 grs. ;

Phosphate of soda, 30 grs.

Divide into three wafers; each one at an hour's interval, and repeated during three days.

Or—

Powdered squills, 1 gr. ;

Powdered digitalis, 1 gr. ;

Powdered scammony, 1 gr.

For one pill, thrice daily.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, April 2nd, 1905.

THE ETIOLOGY OF CANCER.—*Discussion*

Continued.

HR. V. HAUSEMANN said that what had been spoken of as cancer epidemics were only accidental frequencies in small localities. The occurrence of cancer *à deux*, when husband and wife were affected, was not strikingly frequent, and even rarer diseases, such as gout and diabetes, which were certainly not infectious, occasionally sometimes affected a married pair.

As regarded increasing frequency, this was ex-

plainable in part (about 2 per cent.) by the fact that other diseases (small-pox, typhoid, scarlatina, &c.) did not cause so many deaths as formerly. Mostly, however, the increase was due to better diagnosis. The statistics of various large hospitals showed that the disease was first discovered after death in about 20 per cent. of the cases. If *post-mortem* examination were obligatory in all cases, the number of deaths from cancer would at once increase by 20 per cent. Debaussy had shown that only intestinal cancers had increased, external cancers remaining stationary. All this pointed to the great importance of diagnosis. Nothing in the increased statistics of cancer justified any alarm as to actual increase.

That very many forms were described in cancer as protozoa depended on our imperfect knowledge of these forms. It was the same formerly with bacteria, but which now could not fail to be recognised. Up to the present we did not know of any protozoa that caused tumours, nor any diseases whatever caused by them that presented any resemblance to cancer. The coccidia disease of rabbits consisted in visible tumours (cysts) of the liver due to the bilharzia disease of the bladder; the cancer developed on the base of a chronic inflammation and was not caused immediately by the bilharzia.

Whoever had found cancer parasites and described them must prove that the former were really parasites; he must not expect the sceptic to show that they were not.

Up to the present no cancer parasite was known, and it had not been proved by any fact that cancer was of parasitic origin.

As regarded heredity, we were referred to the statements of patients and frequently to tradition. How reliable these were was shown by the Bonaparte family, which was formerly pointed out as an illustration, whilst now it was known that with the exception of Napoleon himself, his father was the only one who suffered from it. Where cancer was really frequent in a family, it might be accidentally so. If cancer were hereditary it would have to be present in the ancestors of sufferers. Probably a disposition towards the disease was hereditary.

Acute injuries could not cause cancer; they could make it worse or draw attention to it. If the question came up for decision in an ascendant case the possibility of a connection could not be disputed, and the German law only required the possibility of such a connection. But the scientific question was quite another one. Of importance for the development of cancer were chronic injuries (mechanical, chemical and thermic), from which it appeared that the favourite sites of cancer were where chronic injurious processes had been in play. No theory fitted all cancers; only one thing was correct, and that was that cancer, like all humours, arose through the mutual action of irritation and irritability. But we do not know any certain irritant for cancer, and up to the present it was extremely doubtful if such existed.

Hr. von Leyden spoke on the

PARASITIC THEORY OF CANCER.

and confessed himself to be a believer in it. All the clinical features laid, he thought, upon the observing physician that the disease was a parasitic one. Thus theories that explained cancer from the interior of the body (*aus dem innere des Körpers*) had no support. The theories of Cohnheim and Ribbert could not stand. Injury could prepare the way for cancer, but it could not cause it. Also, the disposition to it was hereditary, but not the cancer itself.

The infection theory was supported by the fact that the disease generally occurred in organs that were connected with the outer world.

Among animals the disease only occurred in the domestic ones; originally it was a disease of man. It was most frequent where population was dense. Among the negroes of Africa it did not occur, as reliable travellers and medical men had shown. On the other hand, it occurred among the negroes of America where they were in constant contact with

whites. Therefore racial peculiarities were not an absolute protection.

The transference of cancer had taken place only when the cancer cells had been transferred, but he denied that the conception of transplantation and infection should be separated so sharply from one another as the previous speaker had insisted on. What was to be desired was that the transplanted cancer cells always set up cancer. Michaelis had succeeded in producing it through five generations of mice. Spontaneous transference of cancer also took place between animals kept in the same cage.

All these facts, as well as the anatomical data, were in unison with the parasitic theory. What the parasite was was still doubtful.

A METHOD OF DETERMINING THE SEX IN UTERO.

Dr. Weill, of Langenschwabach, publishes an interesting paper in the *Monatschrift f. Geburtshuelfe und Gynaecologie* (Bd. xxii, Hft. 3), edited by Professor Martin, in which are given the results of some experiments performed with a view of studying the influence of different foods and poisons in determining the sex of animals.

According to this authority both reproductive cells (male and female) struggle for superiority in which the stronger one wins. The strength of a cell depends upon (a) the mass (M), (b) the velocity (V)

$$\therefore \frac{Mv^2}{2} = \text{kinetic energy}$$

Whatever has any influence on one of these factors influences equally the sex. In the female reproductive cell the mass preponderates, in the male cell the velocity; consequently the strength of the female cell will be more influenced by alterations in the mass, that of the male cell by modifications of the velocity. All these axioms have been fully corroborated by experiments. The animals subjected to these experiments have been bees, rabbits, pigs, cattle; sometimes one at other times both parents were experimented upon. Of 100 cows 95 were successfully influenced in this way (double-sided influence); and the same success was achieved in 50 cases with pigs, in which the influence was one-sided only. It has been found that the result could be obtained (a) by feeding, that "dynamic" food, such as grass, potatoes, or other carbohydrates, is more beneficial to the male cell (by causing increase of velocity), whilst "plastic"—i.e., nitrogenous food like oats, is more favourable to the female cell (increase of mass). (b) By different poisons, alcohol and morphia causing paralysis, caffeine increase of kinetic energy (V).

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, April 2nd, 1905.

RADIUM ON THE HEALTHY SKIN.

At the Gesellschaft der Aerzte, Schiff gave an exhaustive account of his experiments on himself with the radium rays. He applied a radium capsule containing 55 milligrammes of radium to his own arm.

This 0.85 grain of the illuminant, which he calculated to represent 200,000 units of radial activity, he applied to his own arm a short time for four days; on the fifth day it had a light rose colour and all rays stopped; after this the colour passed through a cycle of colours from copper colour to the cyanotic. A few days after commencing the rays a thick scurf came off as after a burn, associated with a hot burning pain, impeding the free movement of the forearm. Six days after its employment the part was quite normal again.

Holzknrecht said this knowledge could not be accepted as new, as he and Exner had published similar testimony two years ago.

CAVERNOMA OF CRANIUM.

Eiselsberg again showed his patient after the operation whom he exhibited to the meeting a few weeks ago with a presumed angioma. He reported that on the extirpation of the tumour he found the blood-vessels between the scalp and the bone with communication passing into the interior of the cranium. He concluded that the diagnosis of a sinocele was confirmed.

He removed the tumour with the cautery without any bad effect in the recovery.

COSMETIC OPERATION.

Eiselsberg further demonstrated a young prior, æt. 37, who, in September last, got his middle finger nipped off above the distal phalanx by a kneading machine. He was received into hospital, and on November 10th Nicolodni's restorative operation was commenced by removing the second toe of the right foot and grafting it on to the stump of the lost finger. The cosmetic result was a perfect success and gave great satisfaction to the members who were interested in the case. The functional activity of the member is not satisfactory yet, but Eiselsberg anticipates great usefulness, although the patient is greatly pleased with the improvement in holding his pen. The sensation has not yet been established in the toe-finger, which is also against its present usefulness, but time will ultimately overcome this defect.

VOLVULUS IN TRANSVERSE COLON.

Lorenz next gave a lengthy record of a case of volvulus which excited interest from its protracted history. The patient was now twenty-four years of age, and first came under notice in 1900, when she was brought into hospital suffering from perityphilitis. The abscess was incised and radically cured. In the following year she returned to hospital, complaining of pain and swelling of the abdomen associated with vomiting and constipation of a very obstinate character. She was transferred to the surgical department for examination, as considerable doubt existed concerning the real cause of the morbid conditions. Finally it was arranged to remove the appendix as the probable cause of the disturbance, which was accomplished with a satisfactory result.

In January, 1905, she returned again to Hocheneegg's clinic with stenotic symptoms, probably from peritoneal adhesions following the previous laparotomy. There was a hard stiffening of the bowel, about the area of the palm of the hand, in the medial line just above the symphysis pubis. Laparotomy was again performed, when it was discovered that a firm convolution of the bowel in the transverse colon was the seat of the trouble, arising from a band of omentum, causing a volvulus of the transverse colon. The bowel was easily disentangled, and afterwards supported by a few stitches before closing the abdomen. Twelve days later the stenotic symptoms reappeared with more violence than before. Re-laparotomy was performed without delay, when the transverse colon was again found in a convoluted position with adhesions and bands of omentum closing the lumen of the bowel. It was then resolved to perform ileo-colostomy in the region of the nephritic flexure, which was easily accomplished. Since that time no other changes have taken place, and the patient now promises to recover, although very much emaciated at the present time.

Volvulus of the transverse colon is a very rare occurrence, and can only be explained as a congenital abnormality where the omentum is unusually long.

ATROPHIA FACI BILATERALIS.

Stegmann brought forward a young woman, æt. 26, who had suffered from bilateral facial atrophy, and had been treated by Gersuny with vaseline and the oil of vaseline for the cosmetic effect. Photographs before the operation was commenced showed the patient to be apparently about forty years of age. The operation has quite restored her youthful appearance. He discussed the advantages of vaseline and the oil of vaseline over paraffin, as the former was more easily melted than the latter. On the dangers of thrombi he was of opinion that this depended very much on the operator himself in not wounding any large vessel with the needle. To avoid this he recommended aspirating the needle first before injecting the oil, which is a technical minutia.

LICHEN STROPHULUS.

Escherich exhibited a child, æt. 11 months, with a hard isolated rash. Each point or tubercle rose from a healthy skin, having a white or yellow top containing serous fluid. No general disturbance or itching was

present, judging from the behaviour and humour of the child, which would distinguish it from its close ally, lichen urticatus, the latter having an efflorescence at the base of each tubercle that was quite absent in the child produced, and which is not so uncommon as the former.

Special Articles.

NAUHEIM, PAST AND PRESENT.

[FROM OUR SPECIAL CORRESPONDENT.]

MEANDERING through Germany not many weeks since, I found myself at Frankfort, and as this city is not far from Bad Nauheim, famous as the first and last resort of cardiac invalids, it occurred to me to take advantage of the opportunity to investigate the treatment for myself. On nearing the town one's curiosity is aroused by the appearance on the horizon of huge structures that might be fortifications or aqueducts, or canal walls. They turn out to be immense stacks of brushwood in bundles through which the waters are allowed to filter. The excess of calcium salts is deposited on the twigs, which are thus "petrified." I shall, however, refer to the waters later on. On entering the town, which is remarkably clean and neatly laid out, one finds in its centre the grounds in which stand the bathing establishments, mostly of a provisional construction in wood and iron. Beyond is an immense park well provided with delightful shady walks, an extensive lake and ideal golf links with an incredible number of holes duly distributed over well-kept turf. The impression is decidedly pleasing, for German orderliness is everywhere obtrusive.

I was recommended to put up at the Prince of Wales' Hotel, and had no reason to regret the selection for it was near the bathing grounds and very comfortable withal. Early next morning—for business commences at a very early hour in Nauheim, appointments for consultations being made for any time after 6 a.m.—I called on Dr. Schott, of whom the natives speak "with bated breath and whispering humbleness," since in his person is incarnated the prosperity of this now important watering-place. Being nearly the end of the season the great man received me without undue delay, and was even good enough to describe the main lines of treatment, and to promise to show me the springs on the following day.

Thirty years ago Bad Nauheim was an insignificant village, but little known, overshadowed as it was by its great neighbours Homburg, Wiesbaden, &c. Dr. Schott and his brother, by sheer hard work based on careful investigation, succeeded in attracting the attention of the medical world to the remarkable effects of the Nauheim treatment in various morbid states, more particularly in disturbances of the circulation associated with degeneration of the myocardium. The Nauheim treatment of ten or twenty years ago comprised a definite combination of hydropathic and gymnastic procedures and could conveniently be described under that name. It was faithfully carried out by the three or four physicians who then comprised the *corps medical* of Nauheim, and the British practitioner who sent patients there knew approximately the nature of the treatment he was advising. Things have changed since then. The number of practitioners has increased to upwards of fifty, and as they cannot all compete on the same lines the late arrivals have struck out methods of their own in which electricity, Zander exercises and even hypnotism play their part. It follows that the treatment which patients may undergo at Nauheim need not necessarily be what is generally understood by the "Nauheim treatment," in other words, the latter has become an uncertain quantity. It seems to me that when we wish to give our patients the benefit of the Nauheim treatment, as generally understood, we ought to adopt a more distinctive name—indeed, it cannot be better described than as Schott's treatment, since it is the procedure by means of which the two brothers gained for Nauheim its therapeutical fame.

The distinctive feature of the Nauheim thermal waters is the large amount of free carbonic acid gas they contain. Issuing at a temperature of 80° to 95° F. from a depth of some 550 feet, the pressure of the gas throws a jet nearly sixty feet into the air. The jet has the white opacity of foam, and it falls back into the reservoir in seething masses where the surplus gas is given off. The effervescing baths (*sprudelbäder*) are delivered straight from the main, and the roar and rush of the water as it pours into the bath is calculated to startle the nervous patient. The body of the bather becomes covered with minute bubbles of gas, which



exert well-marked effects on the peripheral circulation, the skin becoming of a bright red colour. This, however is not the bath currently employed. For general purposes the natural water is attenuated *ad infinitum*, according to the effect which it is desired to produce. The waters contain 2 or 3 per cent. of the chlorides of sodium and .1 to .2 per cent. of chloride of calcium, along with iron and free gas. There are several springs that furnish drinking waters, one, the Ludwigs Brunnen, containing bicarbonate of magnesium, sodium, lithium, and calcium.

The essential feature of the Nauheim treatment proper is a judicious combination of methodically performed movements and graduated baths. It is obvious that patients who are suffering from tissue degeneration in which the cardiac muscle participates require to be handled gently, so to speak. The heart must be prepared for the course of treatment, and nothing but disaster is to be anticipated should the sufferer's impatience be allowed to influence the sequence that experience has shown to be indispensable to lasting success. I had ample opportunity of watching the treatment, balneological and gymnastic, and I was struck by the scientific method enforced throughout. Nothing could be more interesting than to watch the effect on arterial tension of the first few *saunces*, indicated by the sphygmograph, effects at first ephemeral, then more and more durable, showing the return of tone in the degenerate myocardium and the progressive diminution of the dilatation. It is the custom with many to sneer at the importance attributed to baths as a therapeutical agent, but in the treatment of the cases under consideration it can occur to none to deny the powerful and even lethal influence that an ill-regulated course of treatment may inflict upon the

diseased heart. Inasmuch as the salient feature of the treatment is the application of exercises carefully graduated in order to avoid overstrain, these results can often be obtained elsewhere by baths artificially prepared, but the temperature, richness in salts, and duration of the baths have to be regulated, and, at any rate to begin with, the nature and duration of the exercises must be under direct medical supervision.

Dr. Schott particularly insisted on the fact that the exercise must be conducted by trained hands, with close observation of the patient so that the first signs of dyspnoea or increased rapidity of the pulse may be detected, or, rather, may be guarded against. For this reason he disapproves of all mechanical substitutes for human intelligent control such, for example, as the ingenious Zander apparatus. Excellent as these appliances are in local lesions of joints, they are ill-suited for employment in persons whose myocardium threatens failure—has indeed failed to the extent of yielding to the dilating circulatory forces.

Operating Theatres.

KING'S COLLEGE HOSPITAL,

EPIDIDYMECTOMY—GRAFTING OF VAS INTO BODY OF TESTIS.—Mr. PEYTON BEALE operated on a man, æt. 30, whose history was as follows:—Three years previously he had suffered from tubercle in the left testis and epididymis, and these had been completely removed, the vas being divided high up. Now there were several tuberculous masses in the right epididymis, and Mr. Beale stated that in a case of the same kind upon which he had operated some months before he had completely removed the epididymis, severing the vas, and had then grafted the cut end of the latter into the body of the testis, believing that the vessels of the vas would bring a sufficient blood supply to the testis to prevent it from sloughing or from undergoing atrophy. He therefore decided to perform the same operation in the present case. Having incised the upper and front part of the scrotum, the testis itself was found to be normal to the naked eye, but the epididymis was full of tuberculous masses. The vas was divided about three-quarters of an inch above the testis, and the whole epididymis was dissected away, leaving the testis quite free. A small crucial incision was made through the tunica albuginea, the cut end of the vas pushed in, and secured with four fine catgut stitches. The scrotal wound was then sutured, a small gauze drain being left in its lower angle. The wound healed rapidly, the drain being removed on the second day. When the patient was discharged, about fourteen days after operation, it was noticed that the testis was tender on pressure and somewhat larger than normal. Through the kindness of Dr. B. R. Turner, of Oundle, the progress of the case was reported from time to time, and about six months after operation he stated that the testis was about the normal size, but rather tender where the vas could be felt joining it. Mr. Beale remarked that any means whereby the testis itself could be retained *in situ*, in cases of tuberculous epididymis, must be of considerable value. He had seen several cases where a double castration had been performed in men under forty, and the patients were most pitiable objects. Of course, the procedure adopted in this case could only be carried out when the disease was limited to the epididymis, but he firmly believed that grafting the cut end of the vas into the testis would be found a useful and safe means of preserving the organ, and he hoped to perform the operation in

all suitable cases coming under his care and to report them afterwards.

ROYAL EAR HOSPITAL.

OPERATION FOR INFLUENZAL MASTOIDITIS.—Mr. MACLEOD YEARSLEY operated on a young woman, æt. 27, who had been admitted for acute influenzal mastoiditis. Five weeks before she had had an attack of influenza followed in two or three days by severe pain in the right ear. The pain lasted a few hours and was partially relieved by discharge. On examination, the patient showed tenderness on pressure over the region of the right mastoid antrum. On inspection with the speculum there was marked bulging of the superior posterior meatal wall and a small granulation could be seen in the region of the aditus. The temperature was 99.2° and the patient looked somewhat anxious and ill. There were no other symptoms, vertigo and nystagmus being absent. The watch was not heard on contact, and the tuning-fork showed slight loss of bone conduction. The night before operation the temperature was subnormal. The girl was anaesthetised with chloroform and the Schwartze operation performed. An incision was made in the posterior auricular groove, and the tissues covering the bone pushed forward. The spine of Henle was well marked and the antrum was quickly reached by chisel and gouge. As soon as it was opened a considerable amount of pus welled out. The whole bony tissue of the mastoid, with the exception of the cortex, was found to be disorganised, consisting merely of softened bone and granulation tissue. This was removed with a sharp spoon right down to the tip of the process and the aditus carefully curetted; the middle ear was left untouched. The large cavity left by the operation was syringed with carbolic lotion, filled with iodoform emulsion, and packed with gauze, the upper part of the wound being closed by sutures. Mr. Yearsley pointed out the rapidity with which the mastoid process had been destroyed in this case, and remarked that such destruction was, unfortunately, only too common in influenza. He had met with cases in which complete destruction of the mastoid had taken place within fourteen days from the onset of the disease. In the present case the indications for operation were clear; the pain on pressure and the bulging of the meatal wall being either of them alone sufficient to justify surgical interference. In some cases one might be a little puzzled to know precisely whether to operate or not. Only two months previously he had operated upon a case of influenzal mastoiditis in which all symptoms had cleared up except tenderness over the antral region. In that case also the whole process was found to be destroyed, the bone over the lateral sinus being rotten for an area of quite a square inch, and being also on the point of perforation into the digastric fossa. In cases in which the indications were so slight, Mr. Yearsley was of opinion that less harm could be done by operation than by waiting. He also pointed out the frequency of a subnormal temperature in post-influenzal mastoiditis; this he believed was a feature in other post-influenzal conditions, and it was a point to be remembered in dealing with the sequelæ of that disease. In the present case he hoped to attain a good result as regarding the hearing.

Mr. HAYES FISHER intends to introduce into the House of Commons on Monday a Bill to provide for the exemption of hospitals in London from the local rates.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, APRIL 5, 1905.

VACCINATION FEES.

DURING the late prevalence of small-pox in London, there was, not unnaturally, a vast increase in the number of vaccinations and re-vaccinations, and a similar increase occurred, too, in many parts of the country which anticipated possible invasion by the disease. The guardians in these districts consequently found themselves called upon to foot bills for the public vaccinators that amounted in many cases to considerable sums, and a good many boards objected to being put to so much expense. This discontent was more marked, of course, in anti-vaccination circles, and led to a good deal of correspondence with the Local Government Board and various members of Parliament. The agitation thus set on foot resulted in Mr. Long appointing a committee to inquire into the whole case of the fees paid to public vaccinators, and although this committee reported in April last year, the report has only just been presented to the House of Commons. Properly to understand the issues involved, it must be recalled that the 1898 Act was designed to increase the number of vaccinations by placating the opponents to the administration of the previous Acts, and to do this not only was the conscientious objector introduced to an admiring public, but also it was enjoined that only glycerinated lymph should be employed for vaccinations paid for by the Government, and that the public vaccinator should offer vaccination to the individuals to be operated on by means of a notice and a personal visit to the house. To recompense him for the extra trouble thus imposed, the fees payable to that official were raised to a minimum of five shillings for each successful primary vaccination at the person's home and half-a-crown for each such vaccination at the doctor's surgery or elsewhere than at the person's home. The Government, therefore, intended two things—first, that the number of vaccinations should rise

owing to decreased opposition, and secondly, that the public vaccinators should receive considerably enhanced sums each quarter. Both these results occurred, in spite of the gloomy vaticinations expressed in many quarters. Instead, however, of enjoying quietly their triumph—for triumph it was over each extreme section—with the usual inconsistency of English Governments when vaccination is in question the present Administration quailed before the resentment of the Boards of Guardians who were the instruments of their policy, because, forsooth, that policy had turned out successfully. So the committee was appointed to see how the matter could be patched up, for, as we said last week, the Government have no intention of proceeding to the logical conclusion of a successful primary Vaccination Act, namely, a Re-vaccination Act, and are only too willing to let the whole subject drop, provided that another compromise can be tinkered up. Such a compromise is attempted in the Committee's recommendations. In the first place they propose that the privilege of being attended at home by the public vaccinator shall be available only to those who have their child vaccinated before it is four months old, unless the operation has been postponed on the ground of health, and also that the public vaccinator shall not be obliged to attend at the homes of children over a year old who have, up to that time, escaped the vigilance of the vaccination officer. These recommendations are retrogressive from the point of view of catering for the public convenience, whilst it is proposed to balance them from the public vaccinator's standpoint by allowing him four, instead of two, weeks within which to obey the summons to vaccinate issued by the vaccination officer or parents. But the fee question was really the burning one, and it has been tackled by the Committee in a way that will, we think, be little acceptable to the public vaccinators. It is proposed to graduate the scale of minimum charges, so that three shillings shall be paid for vaccination at the child's home if within one mile of the doctor's house, four shillings if between one and two miles, and five shillings if between two and three. For journeys over three miles a special fee is to be arranged between the parties. Now it savours of disingenuousness to speak of "minimum" fees in this connection, as the Committee must have known well enough that the minimum fees are all that the public vaccinators ever have got, or ever will get; and it is difficult to conceive of any circumstances that would induce any board of guardians to pay more than the minimum fee. The reduction in the amounts payable to public vaccinators under this scale will be very considerable, as it stands to reason that the large bulk of the ordinary vaccinator's work lies within one or two miles of his residence, and to expect medical men to go through the process of sterilising their apparatus for each patient, to keep registers, to bear the expense of postage, and to pay two visits—one to vaccinate and the other to inspect—for the sum

of three shillings is setting but little store on the value of a professional man's time, to say nothing of the cost of horseflesh and boot leather. We have no doubt the introduction of this new scale will be strongly resented by the public vaccinators themselves, and as a matter of professional dignity we think a protest should be made against a system of sweating that makes the doings of several friendly societies look rosy by contrast. The Committee, however, say that they make these recommendations on the understanding that the fee-system is to be continued, but they suggest that in large towns it might be possible to appoint whole-time officers at a salary to do nothing but vaccinate, and that in smaller districts it might be possible to associate the work with that of the medical officer of health or of the district medical officer. We doubt very much if the former would be possible; to keep a man of any capacity employed at nothing but performing primary vaccinations would be ludicrous. As to the two last, the medical officer of health is the natural officer to do the work, but as he is appointed by the sanitary authority and not by the guardians, a change of law would be necessary. As things stand, the district medical officer in country places generally holds the post of public vaccinator as well.

THE NOTIFICATION OF CONSUMPTION.

THE famous "crusade against consumption" appears to have lost much of the vigour that characterised its operation some years back. That it still remains, however, as a living and active educational force among our countrymen cannot be for a moment doubted. The very magnitude of the problem is sufficient to weary the most undaunted energy. Even now some of the most essential factors of the situation linger in the regions of scientific doubt. At the present moment Professor Koch, a man whose name will ever be associated with the history of tuberculosis, disputes the community no less than the communicability of bovine and of human tuberculosis. On the other hand, English authorities refuse to adopt that view, and have repeatedly and advisedly expressed their opinion to the contrary. Yet British sanitarians, admittedly in the forefront of practical health work, have not hitherto carried their pious opinions into practice. Otherwise the control of meat and milk supplies so as to exclude food infection would long ago have been established on a sound and rigorous preventive basis. All the great English authorities proclaim with one voice the communicability of the tubercle bacillus from the lower animals to man. For many years past they have insisted upon the probable relation of milk to infantile tuberculosis—one of the most deadly and universal causes of the excessive child mortality that constitutes a standing reproach to modern civilisation. But what have the preachers done to reduce their gospel to practice by excluding tuberculous milk from the national food supply? So far, nothing has been done beyond a

few isolated attempts here and there to provide a public service of sterilised milk for the use of the poorer classes. No proper system of exclusion of tuberculous cows from dairies and from dairy farms has been yet devised. The medical officer of the town is powerless in the matter without the active co-operation of his brother medical officer in the country. And so, while sanitary administration is hampered and chaotic, the infants of the United Kingdom are offered up to the Moloch of tuberculosis in whole hecatombs. Legislation is wanted to deal with the milk supply with a drastic and well-informed measure. As with milk so with meat. Inter-communicability between the lower animals and man means that the flesh of all tuberculous animals is a potential source of infection to the consumer. Yet scientific meat inspection as practised, for instance, in Germany is non-existent in the markets of Great Britain. Of what use is it to attempt to stamp out tuberculosis by treating a small percentage of human sufferers in open-air sanatoria? Far better spend the money in weeding out tuberculous cows and pigs from our farms and dairies, and in the rigorous skilled inspection of our meat supplies. To permit the source of the evil to go on scattering the pestilence broadcast on the one hand, while we treat a few of the victims of that evil, is to commit a logical blunder of ludicrous proportions. Is it small wonder that medical men, under such circumstances, take a faint interest in the voluntary notification of tuberculosis? They realise only too well how small and feeble the plaster they are asked to apply to a small portion of a deadly gangrenous sore, the cause whereof remains untouched. Well may they ask why the sanitarians do not go to the root of the matter and look after meat and milk. It is, indeed, not a little curious that as a nation we are content to let these things be, after having given an absolute negative to Koch's assertion of non-inter-communicability. Our denial of his precept, however, is more than outweighed by our neglect to put our own belief into practice. This is not the logical state of mind, nor the energy of action that has secured for the United Kingdom practical immunity from plague, cholera, typhus, and kindred infections.

Notes on Current Topics.

A Substitute for Competitive Examinations.

THE competitive examination only fails to be an unmixed evil by reason of the fact that it eliminates the influence of nepotism from public appointments or rewards. When that has been said, we think all that can possibly be put to its credit has been granted. Medical men in every sphere of practice and on both sides of the Atlantic are impressed with the evils of the system, and most sound educationalists are, too. The difficulty in doing away with examinations, however, has always been that no efficient substitute for them has so far been forthcoming. For this reason we hope that the interesting experiment that is now being carried out in connection with entrance to

the Navy will be closely watched by those to whom the welfare of mind and body of the young is a matter of concern. In 1903, the stupid plan of selecting officers for the most important service in the country by finding out whose brains could contain the largest number of facts in algebra or Latin at the age of twelve or thirteen was done away with, and in its place a committee of men of thought and of action was appointed to interview candidates and find out what sort of stuff they were made of. Work of such a kind needed gifts of a particular nature, but the committee on the whole was well composed and their work seems to have been conscientiously done. Four sittings have now been held, and the members of the committee have lately given their views on the value of the method. They are unanimously in favour of it, although all have suggestions to make with a view to improvement. The danger with young boys brought to the ordeal of being interviewed by admirals, head-masters, and peers of the realm would be thought to lie in the youngsters' nervousness not enabling them to do themselves justice; but in practice this seems not to have been so, owing principally to the sympathy and *bonhomie* of the naval officers. In no case did this fail to put a boy at his ease, and when at his ease they were able to find out whether he had the makings of an energetic and trustworthy man in him. It still remains to be seen how the boys thus chosen will develop, but the plan holds out such prospects of good that we hope it may be given wider trial.

A Doctor's Bravery.

THE day-in, day-out self-sacrifice of the country practitioner's life is so much a commonplace of existence that it ceases to excite interest, much less enthusiasm, among people generally. The daily risks, too, to which every medical man exposes himself are never considered. "Why don't doctors catch things?" they ask languidly at times, ignorant or oblivious of the fact that doctors catch things and die just as other people do, only more often because of their greater opportunities of exposure. Among members of the profession, however, devotion to duty can be appreciated, and an instance which would be remarkable if it were not that it is precisely what we hope would be done by every doctor in similar circumstances should be recorded that occurred last week off the coast of Donegal. During the height of a furious gale a signal was made from the island of Innisboffin that a patient was dangerously ill, and without a moment's hesitation Dr. McDonald, of Tory, went down to the shore to find volunteers to row him over. The only possible conveyance was an open boat, and with four plucky fishermen to man it Dr. McDonald proceeded on his errand. The wind was dead in their teeth, the rain descended in torrents, and a fearful sea was running; but gradually the little boat worked its way across, and the patient was attended to. By the time the return journey was started the storm was even worse, and the

boat, in spite of constant baling, was soon half-full of water. In this plight they struggled on for a while, but a squall struck the vessel suddenly, and overturned her. The crew managed to cling to the keel of the boat, but Dr. McDonald was swept away by the waves and would inevitably have been drowned had not one of the men swam to him and given him an oar to cling to. Coll, the man who rescued Dr. McDonald, managed to take his clothes off in the water, and reached the shore by swimming, whilst in the meantime another boat was put off from the mainland to carry help to their comrades in the water. In all, it took something like an hour before the latter were all rescued, Dr. McDonald being nearly exhausted when he was picked up. Deeds like those of Coll and Dr. McDonald deserve a more enduring memorial than mere record in current journals can give them.

Medical Men and Motor Cars.

No medical man who has had a trustworthy motor car would ever return to the horse and carriage as his means of transport. Whatever joys may be extracted from driving a good horse are more than compensated for by the saving of time and the still greater blessing—the ability to start anywhere at a moment's notice—that the ownership of a car confers. The two questions that are constantly agitating the mind of the country doctor who hankers after a car are that of cost and that of "reliability"—as the trade term goes. The initial cost is certainly higher for the smallest useful car than that for which a horse and trap can be obtained, but the up-keep of an average car, properly managed, seems to be about the same as that of a single horse. From an interesting article by Mr. Henry Norman, M.P., we learn that a really sound small car can be bought for £185, but that to make such a car thoroughly useful tyres of a larger size than those fitted by makers should be used. At the end of five years' running this car should still be in good enough going order to fetch £85 in the market, so that if the user wished to get a new one, he would only be £100 out of pocket as the result of his experiment. The depreciation, therefore, Mr. Norman writes down at £20 a year, and giving the car five thousand miles a year to run, he estimates that the following would be the motorist's budget: Petrol, £12 10s.; tyres, £20; supplies and sundries, £7; replacements and repairs, £10; Inland Revenue licence, £2 2s.; insurance, £5; registration, £1; driving licence, 10s. 6d.; total, £58 2s. 6d. It will be noticed that no wages for the chauffeur are included, as Mr. Norman expects the amateur to pick up all that is necessary in a couple of months and to delight in attending to his car. To such the prospect is enticing.

Laryngology on its Dignity.

THE laryngologists of this country have just had a very pleasant *divertissement* in the shape of the Garcia centenary—an occasion probably unique in the history of any science or art. They

have foregathered in force to do honour to the founder of their craft, who, not a medical man himself, yet laid the foundation-stone of one of the most flourishing specialities in medicine. We may note in passing that the term "specialist" is now unblushingly adopted by many members of the profession who twenty years ago resented the appellation when it was applied to them by the public. The general surgeon who makes a special study of the eye has almost vanished, the ophthalmic surgeon—or "oculist," as people to his disgust insist on calling him—having taken his place; the old-time physician for diseases of women and children is supplanted by the operating gynaecologist; and the special departments of hospitals are nearly all in charge of "specialists." The end of this fissiparous process is, however, not nearly in sight yet, and it might form an interesting speculation to guess at the degree of refinement it will have arrived at in another half century. At any rate, for the present the laryngologists are very angry with the Organising Committee of the Lisbon International Medical Congress because, instead of being given a section of their own, they have been included with the otologists, the rhinologists, and—worse still—the stomatologists. Stomatologist, we may observe, is a Portuguese euphemism for "dentist," and the pure laryngologists have as great an objection to being lumped together with the pure stomatologists as to being put into a subsection of general medicine. The people, however, that they seem to have the least desire to be associated with are the otologists, and the latter, for their part, also wish to have a section of their own. In order to maintain the dignity of their speciality under these trying circumstances, it is understood that the laryngologists will abstain from sending any delegates at all to the Congress. So far we have heard of no protests from the tracheologists, but perhaps they are not able to make their voices heard, owing to the vocal cords being already monopolised. A vision crosses our mind, as the late Lord Salisbury would have said, of a mutual understanding being arrived at in the year 2000 whereby the right bronchologists would agree to hold their meetings in Tokio if the left bronchologists would promise to hold theirs at St. Petersburg. Imagination pales when we think of the possible feelings of bronchiole-logists.

Detective as Resident Patient.

IN a divorce case in which the names of two medical men were involved, the painful details of the charges and counter-charges were relieved by the appearance in the witness-box of a detective. This functionary had gained access to the bosom of the doctor's family by the stratagem of posing as a sufferer from neuralgia, among other complaints, and as needing constant supervision and treatment. The necessity of taking resident patients into the house is often regarded as disagreeable one by doctors, and the unpleasantness is not alleviated when it is found out that the *protège* has used his position to become the "chief

among you takin' notes." The "chief" in this case availed himself of his opportunities to the full, as he said that he found himself taking notes all day long. There is something about a procedure of this kind that leaves a nasty taste in the mouth, and if there is a moral to be drawn from it, that moral would be that medical men should make very careful inquiries into the antecedents and connections of patients who propose to reside with them. The footing is an intimate one, and may easily lead to consequences not contemplated at the beginning of the arrangement. Apart, however, from the actualities of the case, the situation lends itself to several piquant developments, and it is one that we do not remember to have seen employed by the plot-seeking detective story writer. The private agent as resident patient might be conducted through a series of amusing adventures if handled with skill and sympathy, and we would commend the idea to the creator of Sherlock Holmes. Could not Dr. Watson be made to entertain such an angel unawares? As a foil to Sherlock Holmes, poor Dr. Watson always falls so readily into the most obvious traps that it might be possible even to make him take his acute friend into his household without recognising the identity of his guest—that is, of course, if Dr. Watson could spare any time from his abortive blunderings after criminals to give to the practice of medicine.

Polyglot Physicians.

THE barrier placed by differences in language in the path of knowledge is clearly to be regretted. There are many points in favour of the establishment of a universal language, but whether such a tongue be Esperanto or Latin seems to us to be immaterial so long as continuity of thought remains unhindered. Scientific and medical terms, themselves chiefly derived from the ancient classical languages, offer less difficulty, perhaps, than others, so that the physician who does not possess much in the way of conversational powers in a modern tongue is often able to follow quite readily the medical articles in foreign medical journals. There are, however, certain parts of the Metropolis where the language difficulty presents itself in a practical fashion as far as speaking and hearing it are concerned. A trip to Aldgate and neighbourhood lands one, as it were, in a strange world, in which the people, for the most part, speak an almost unintelligible jargon, where newspapers and public notices are printed in Hebrew characters, and where the countenance of nearly every passer-by betrays its Semitic origin. We have heard lately of the praiseworthy attempts made by the Metropolitan police to learn Yiddish, a knowledge of which will probably serve them well, but what about the medical practitioners in the district who come into intimate contact with the daily lives of these strange folk? Some of them are of their own nationality, but others, especially those who only visit the public dispensaries once or twice a week, find the language question by no means an easy task. It

is one thing to acquire a few stock phrases, but it is another to have one's interrogations met with a voluble flow of extremely bad German. Other parts of London are colonised by other races, such as French and Italian, who are easier to understand. The next thing we shall hear of, no doubt, will be the establishment of schools where physicians may receive colloquial instruction in that particular tongue spoken by their patients.

"Medical Register," 1905.

THE publication of the *Medical Register*, 1905 (Spottiswoode and Company), brings to light many interesting facts, one, notably, that the number of new names last year was lower than it has been for nearly twenty-five years. At the same time the 1904 returns do not raise any alarm as to insufficiency of medical practitioners, who amount—British, Colonial and foreign—to no less than 38,492. The number of names removed through death in 1904 was 545, which is rather below the average. Nine men were registered holding colonial diplomas or degrees, while there are twelve Italian doctors, six of them practising in England. The volume displays the usual accuracy in addresses, and evidences much care on the part of the compilers. The appearance of the *Register* reminds us of the rapid flight of years, each one following hard on the other and each marked by more or less progress in the numbers, the knowledge, and the standing of the medical profession.

Water Drinking in Typhoid Fever.

FOR some time physicians have recognised more and more the value of free administration of water in typhoid fever, and it is customary to see that the patient drinks at least a couple of pints in the day. Dr. Cushing, of Cleveland, has recently, however, conducted an interesting clinical experiment on the effects of giving greatly increased quantities of water during the course of typhoid fever. By regular administration of about five ounces of water every fifteen minutes during waking hours he was able to effect that each patient received from eight to fourteen pints per day, while, in addition, he drank about three pints of other fluid—milk and albumen water were usually administered. These apparently enormous quantities of fluid were taken with ease, and naturally produced a marked increase of urinary secretion. The polyuria, after the second day under treatment, was found to keep very exact pace with the fluid drunk, though any marked diarrhoea or sweating, of course, upset the correspondence for the time being. Of the general result in diminishing toxic symptoms, Dr. Cushing thinks highly of heroic water-drinking in enteric fever, and his experience now exceeds one hundred cases treated in this way. Headaches became much less common, and the general comfort of the patient was increased. The tongue and mouth remained clean, while nausea became unusual. Restlessness, sleeplessness, and delirium caused less trouble, while the

bath, which Dr. Cushing uses in his practice whenever the temperature reaches 102-5° Fahr., was but seldom necessary. Contrary to expectation the movements of the bowel were practically unaffected by the water treatment. The patients themselves soon came to like the treatment, and in many cases voluntarily increased the amount of water taken. The method is rational, since it is natural to expect a good result by the constant dilution of the toxic blood, and, being very simple, it deserves a wider trial.

Acute Pancreatitis and Pathology at Inquests.

LAST week a more than usually interesting cause of death was disclosed at an inquest held in Brighton upon the body of a visitor to an hotel in the town. The deceased, who was fifty-seven years of age and enormously stout, was found dead in his bedroom. The medical man who made the *post-mortem* examination testified that death was due to syncope caused by or associated with acute hæmorrhagic inflammation of the pancreas. He added that the affection named was extremely rare. This occurrence suggests the vast field of pathological research that might be opened up by a systematic investigation of the facts disclosed in *post-mortem* examinations ordered by coroners. The pancreas, as everyone knows, is an organ of which a great deal remains to be learnt both by the physician and by the pathologist. In cursory *post-mortem* examinations it often escapes notice altogether, speaking broadly. Neglect of *post-mortems* by general practitioners is likely to bring its own punishment in the loss of a lucrative and most interesting branch of professional work. The value and necessity of attendance in the *post-mortem* room and of practical work therein can hardly be too strongly impressed upon the medical student. Many men go out into the rough and tumble of medical practice without ever having performed a "sectio cadaveris," although they may have passed high standard theoretical examinations and may be able to append many titular letters to their names.

Poisons in Accident and Suicide.

THE Registrar-General's tables for England and Wales for the year 1903, which, with official punctuality, have recently been made public, show some interesting figures with regard to the accidental and suicidal poisonings during that year. The total of deaths due to accident or negligence was 15,464; of these the deaths of 299 males and 168 females were due to poison; 2,640 males and 871 females committed suicide, of whom 500 males and 229 females chose poison as the means of ending their lives; 146 deaths are returned as due to anæsthetics, chloroform being responsible for 97, or nearly two-thirds; of the others, the A.C.E. mixtures caused one, chloroform and ether one, ether nine, nitrous oxide five, while in 33 the nature of the anæsthetic is not stated. Of the poisons taken by accident, opium, with its derivatives, is by far

the most common, and is credited with 84 deaths. Carbolic acid is still, strange to say, the favourite draught of suicides; except the ease of obtaining it, there is little to explain its position in this respect; it is credited with 141 suicidal and 20 accidental deaths. Oxalic acid, probably for a similar reason, is in great demand for suicidal purposes, having been effective in 89 cases, while only 7 accidental deaths are due to its use. Hydrochloric acid caused 45 suicidal and 10 accidental deaths. There is no separate mention made of poisoning by wood alcohol, a substance responsible for many deaths in America in recent years, but we suppose, if any such have occurred, they are included in the six accidental deaths returned as due to "alcoholic spirits."

The Homeless Poor.

THE census of the homeless poor of London, taken on the night of February 17th, under the direction of the London County Council, showed that there were about two thousand men and women who spent the night without a home. The persons counted were either wandering about, or lying on staircases, in doorways, or under arches. This is surely a large total of destitute and homeless poor, even for a city of the size of London, and it is certain that the census failed to be complete. Moreover, in all probability, a census taken in summer would show a larger number who spend, either by choice or by necessity, the night in the open. It is to be remembered that in many cases it is a matter of choice. On the night in question there were available in the casual wards of the metropolis no less than seven hundred beds, while in common lodging houses there were nearly six thousand beds vacant, where the charge would have been merely nominal. For the few who prefer sleeping in the street or in doorways to resting in a comfortable bed, there is, of course, nothing to be done; but there are doubtless many who, from inability to reach a casual ward, prefer to snatch a few hours' rest wherever it can be found. It would be of help to them if some means were adopted by which they could find out where beds are available, and the easiest means of getting to them. If it were not for the distrust of the police habitually shown by this class of people, the simplest means would be by telephonic message from the various police stations.

Potassium Permanganate in Snake-Bite.

ANYONE who has experience of India or other countries where venomous snakes abound will realise the value of a remedy for snake-bite which possesses the properties of being simple, efficacious, and easily applied. There is little reason to doubt that potassium permanganate possesses these properties, and if the lancet devised by Sir Lauder Brunton be made use of, many lives will be saved which would otherwise be lost. All that is necessary is to cut down immediately at the position of the bite, and to apply a few crystals of potassium permanganate of potash. Sir Lauder

Brunton's lancet contains in a receptacle in the handle a supply of this salt, and it is only necessary, having made the incisions, to reverse the instrument, and press in a few crystals. Captain Leonard Rogers has collected (a) five cases of snake-bite recently occurring, in which the potassium permanganate was applied with entire success. In one of them the bite had been given by a Russell's viper, the most deadly of Indian snakes. It is essential, of course, that any remedy for snake-bite should be capable of immediate application, for the chance of recovery is in reverse proportion to the time given for the poison to spread in the tissues and vessels. There is no reason why every Indian house should not contain a Brunton's lancet, the immediate use of which gives the best prospect of recovery.

Status Lymphaticus.

ALTHOUGH the number of recorded cases of sudden death occurring in so-called "status lymphaticus" is now considerable, we are quite at a loss as yet how to explain the pathology of the condition. In most cases it has been quite unsuspected during life, and only during the autopsy made to explain a sudden death, usually in a child, is it discovered. The only pressing clinical symptom is dyspnoea, and hence the term "thymic asthma" sometimes applied to the condition. As the fatal dyspnoea sometimes comes on during or immediately after anaesthesia induced for surgical purposes, it is of some importance to the practising surgeon. The cause of death in status lymphaticus is still a matter of dispute, for while some regard the dyspnoea as the mechanical effect of an enlarged thymus gland, others look on it as the manifestation of a lympho-toxaemia. Certain cases reported by König and Seigel seemed to favour the former view, as a surgical operation, by merely suturing the thymus to the fascia above the sternum, gave complete and permanent relief to urgent dyspnoea. On the other hand, it is difficult to see how a gradually enlarging thymus could cause the urgent or fatal dyspnoea often observed without some previous symptoms being noted.

The Direct Representative for Ireland on the General Medical Council.

DURING the past week Dr. Leonard Kidd, of Enniskillen, an ex-President of the Irish Medical Association, has intimated his intention of presenting himself next year as a candidate for the post of Direct Representative on the General Medical Council. Dr. Kidd holds the view that the Direct Representative should be a general practitioner, and provided that a suitable candidate can be found, we fancy that many medical men will agree with him. Sir William Thomson has also issued a circular stating that he is desirous of continuing to be the representative of the profession, and points to the energetic manner in which he has discharged his duties in the past. The early date

(a) *Indian Medical Gazette*, February, 1906.

at which the candidates have thought it necessary to issue their respective addresses points to the likelihood of a keen contest.

Proposed Confederation of the London Medical Societies.

OUT of the universe of medical chaos every now and then comes some sound evolution. Hopeless as hitherto have seemed the rival interests of medical charities, of qualifying boards, of defence associations, and of scientific societies, yet now and then the dawn of reason has ushered in some prospect of a future sanctified by the higher qualities of organisation. Sir William S. Church has lately drawn attention to a meeting to be held shortly at the Royal College of Physicians of London, when the question of the desirability of uniting the central medical societies of London will be discussed. This proposal was discussed at the annual meeting of the Royal Medical and Chirurgical Society by the President in his Annual Address, and was well received by those present. It was again mentioned at the anniversary dinner of the Medical Society of London, and again sympathetically received. So far as we can foresee, the amalgamation of the chief medical societies of London could not fail to greatly enhance their field of usefulness, from whatever point of view—social, scientific, or purely educational—the project be considered. A letter from Sir William Church on the subject will be found in our correspondence columns.

PERSONAL.

THE new Sheriff for the county of Cardigan is Dr. Edward Roberts, one of the Honorary Surgeons to the Manchester Royal Eye Hospital. Cardigan is Dr. Roberts' native county.

MR. JOHNSON SMITH, F.R.C.S., on his retirement after thirty years' service at the Seaman's Hospital, is to-day entertained at dinner by the medical staff of the hospital, at the Trocadero Restaurant, Shaftesbury Avenue, London.

A LARGE number of gentlemen concerned with Welsh education have been invited by Principal Griffiths of Cardiff to join a committee for promoting a presentation to Sir Isambard Owen, Senior Deputy Chancellor to the University of Wales on the occasion of his marriage.

PROFESSOR WILHELM ROENTGEN, the discoverer of the rays that bear his name, was born in Lennep, a small place near the Rhine, and has just celebrated his sixtieth birthday. He took his degree in Zürich, and was for several years the assistant of Professor Kundt. In 1876 he was appointed Professor Extraordinarius in the Strassburg University, and received a Professorship at the early age of thirty-four. He is now on the staff of Munich University, being appointed there shortly after his celebrated discovery.

DR. THOMAS POWER, of East India Road, Poplar, has been added to the Commission of the Peace for the County of London.

WE understand that Professor Jacobs, of Brussels, will read a paper in London on Thursday, the 13th inst., before the British Gynaecological Society, on "the Surgical Treatment of Cancer of the Uterus, and its results." A large meeting of members is anticipated on this occasion.

MR. JAMES SHEPHERD, of Rossend Castle, Burntisland, has intimated that he will give £10,000 towards the funds of Dr. Gray's Hospital at Elgin.

DR. F. W. PAVY, F.R.S., has presented a sum of £100 to the funds of the physiological laboratory committee of the University of London.

MESSRS. N. M. ROTHSCHILD AND SONS have sent a donation of £3,000 towards the £100,000 required for Guy's Hospital.

OWING to ill health, Mr. F. J. Marshall has been compelled to resign the post of Resident Medical Officer at St. George's Hospital, which he has held for over thirty years. A testimonial is shortly to be presented to him by his friends at St. George's and elsewhere as a mark of their appreciation of his work for the hospital. Subscriptions may be sent to Sir William Bennett, K.C.V.O., or to the Dean of the Medical School, St. George's.

DR. H. STRACHAN, Principal Medical Officer, Lagos, has arrived in England on leave.

SIR ALLAN PERRY, Principal Civil Medical Officer and Inspector-General of Hospitals, Ceylon, has been made a Councillor of the Municipal Council of Colombo.

DR. J. W. GROMITT has been made an Assistant Sanitary Warden in the Medical and Health Department of Mauritius.

DR. J. M. ATKINSON, Principal Civil Medical Officer, Hong Kong, is coming to England on leave of absence, during which Dr. Clarke takes charge of the Department.

DR. J. J. CULMER, Assistant-Surgeon of New Providence Asylum, Bahamas, has been confirmed in the office of Resident Surgeon-Superintendent in place of Dr. L. D. Parsons, transferred to Gibraltar. Dr. J. Baird Albury becomes Assistant-Surgeon in succession to Dr. Culmer.

THE DUKE OF NORTHUMBERLAND will preside at the annual dinner of the Royal Sanitary Institute, to be held in the Princes' Restaurant, Piccadilly, on Friday, May 12th.

ON March 29th, Principal Donaldson, of St. Andrews University, was presented with his portrait, painted by Sir George Reid, and subscribed for by past and present students and others. The presentation was made by Lord Balfour, the Chancellor, who paid a high tribute to the educational work of Dr. Donaldson.

LORD STRATHCONA has consented to take the chair at the festival dinner of the National Hospital for the Paralysed and Epileptic on Thursday, April 13th, in the Whitehall Rooms of the Hôtel Métropole, London.

THE President of the Council of the University of Liverpool (Mr. E. K. Muspratt) offers to provide an extension of the Chemical Laboratories, at an estimated cost, including equipment, of £10,000. The offer has been gratefully accepted, and several other large sums have been contributed towards current expenses.

TO Sir Frederick Treves, in recognition of the value of his work in connection with abdominal surgery, has been awarded by the Council of the Medical Society of London the Fothergillian Prize for 1905.

MR. HENRY FAWCETT, a Dublin medical student, was accidentally killed on the Dublin, Wicklow and Wexford Railway, on March 25th, by a passing train. Mr. Fawcett had gone in company with some friends to a signal cabin near Killiney Station, and apparently had inadvertently stepped out on to the track.

PRINCE AHMED EFFENDI, son of the Sultan of Turkey, has undergone a successful operation performed by Dr. Djemil Pasha and other surgeons, on whom the Sultan has conferred decorations.

Special Correspondence.

[FROM OUR OWN CORRESPONDENT.]

BELFAST.

Royal Victoria Hospital.—The annual meeting of this hospital was held last week, the Earl of Shaftesbury in the chair. The report showed that 2,908 intern patients had been treated during the year and 1,212 operations performed. The extern cases numbered 22,585 giving a daily average of about 185 patients treated in the extern. The treasurer's statement showed an income of £14,800 for ordinary expenses, and special donations amounting to over £62,000 to capital account. For the first time for many years the hospital closed its year's accounts with a credit balance of about £700. In consequence of this the Board had decided to open two more wards, containing sixteen beds each, which have remained unused since the hospital was opened two and a half years ago, owing to want of funds. In spite of this fact the number of intern cases was larger by 748 than in the last complete year in the old hospital. The plenum system of ventilation, round which a heated controversy raged when the hospital was planned, is working admirably, and the total cost of heat, light and ventilation was £1,637, which is considered very satisfactory. The expenditure works out at 27'6d. a day per person, including patients, nurses and staff, and was an average of £58 16s. 8d. per annum. Lord Shaftesbury, in moving the adoption of the report, referred gracefully to his deep gratitude to the medical science of the city, as represented by his friends; Sir William Whitla and Dr. Calwell, members of the staff of that hospital, and to his good friend, Dr. Manley, for his complete restoration to health after his illness last summer. "I express my thanks to the medical science of Belfast generally and to those gentlemen for the skill and care they gave me, and not only to the medical science, but to the nursing science, of the city I am indebted." (The illness to which Lord Shaftesbury referred was a severe attack of typhoid.) The report of the medical staff, read by Dr. Calwell, in addition to the figures already quoted, said that of the 2,752 new cases received into the wards during 1904, 987 were medical and 1,754 surgical. There were 154 deaths, including twenty-six admitted in a moribund condition. Of the remaining deaths, 78 were due to surgical cases, and 50 to medical. There were 45 deaths after operation, giving a mortality of 3·7 per cent. Dr. Calwell, in speaking to his report, expressed his entire satisfaction with the plenum system. He also referred to the valuable services of Dr. Rankin in the Rontgen ray department.

Royal University Senate.—Six representatives of the graduates of the Royal University are to be elected to the Senate by Convocation and at a recent meeting of the Council of the Royal University Graduates Association it was decided to support the five retiring members, who will stand again, and in the place of Professor Sinclair, who has declined to stand, to nominate Dr. R. W. Leslie, one of the secretaries of the Association. Dr. Leslie is a general practitioner in the suburbs of Belfast, and he has given much time to the work of the Association, and was right-hand man to the late Dr. McKeown, its leading spirit. The Association obtains a large amount of support in Ulster, though there is an influential body of graduates, and specially of medical men, who have consistently refused to have anything to do with it, believing it to be mistaken in its aims and methods. If it should succeed in shaking itself free from the narrow views of the late president it might become a useful body.

Workshops for the Blind.—At the annual meeting of this most excellent charity held in Belfast last week some interesting statistics were read by the secretary. It appears that from the last census there are 4,253 blind

persons in Ireland, being eight per hundred thousand more than in England and Scotland. Of these only 750 are employed in the twelve institutions which are conducted for their benefit, leaving 3,703 practically unassisted and often in great poverty. The number employed in the Belfast workshops is 131, of whom 89 are men and 42 are women. The number employed must of course depend largely on the support accorded by the public in the purchase of the articles manufactured.

Correspondence.

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

PROPOSED CONFEDERATION OF THE LONDON MEDICAL SOCIETIES.

LETTER FROM THE PRESIDENT OF THE ROYAL COLLEGE OF PHYSICIANS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Attempts have been made from time to time to unite the various London societies representing medical science and practice more closely, so as to form a united Royal Society or Academy of Medicine, in which the existing societies would retain their individuality as sections of the united body.

The present appears a favourable opportunity for again endeavouring to effect this unification and I have gathered from many holding influential positions in the different societies that they would not object to such a confederation being again considered. I have therefore consented to preside at a meeting to be held at the Royal College of Physicians on Monday, April 10th, at 5 p.m., to consider whether it is desirable that the central medical societies of London should unite to form one Royal Society or Academy of Medicine; and, if such union is thought desirable, to take preliminary steps to bring about such federation.

The meeting is open to Fellows and members of all medical societies and it is hoped that there may be a large and representative meeting, as it is desired to gather the opinion of the profession and especially of the junior members of it, as well as that of those who are officially associated with the several societies.

I am, Sir, yours truly,
W. S. CHURCH.

March 28th, 1905.

THE RECENT MEDICAL CONFERENCE ON THE TEACHING OF TEMPERANCE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your interesting account of the recent Medical Conference on the Teaching of Hygiene and Temperance, Mr. McAdam Eccles is reported to have advocated the systematic instruction of medical students regarding the action of alcohol in health and disease. No doubt a short course of lectures and demonstrations on the psycho-physiological and pathological features of alcoholism would be of both scientific interest and clinical service. It would be well to know, however, in what way Mr. Eccles considers his suggestion could be carried out, in view of the heavy demands made upon a student's time and energy and the still widely prevailing differences among teachers of medicine regarding the use and abuse of alcohol.

Now that the medical profession as guardians of the public health have demanded that in the elementary schools there shall be rational teaching of hygiene and temperance it is an urgent necessity that means should be found for providing reliable scientific instruction for those whose duty it will be to direct the developing mind of the children.

I am, Sir, yours truly,
Harley Street, W. T. N. KELYNACK.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Sir Victor Horsley at the recent Conference of medical men on the Teaching of Hygiene and Temperance in our public elementary schools, stated that a syllabus of the suggested courses of teaching in hygiene

and temperance for boys and girls in the public elementary schools of the United Kingdom was in course of preparation.

As there appears to be much difference of opinion as to the extent and character of the instruction regarding alcohol and the evils of alcoholism which should be imparted to the children, it seems most desirable that this matter should be fully discussed by members of the medical profession. In view of the misleading and prejudiced opinion clearly expressed in the memorandum of Sir Michael Foster, M.P., recently issued by the Board of Education, it is very necessary that physiologists and pathologists as well as clinicians should be allowed an opportunity of freely expressing their opinion. It is to be hoped that Sir Victor Horsley's Committee will be a truly representative one, and that their proposed syllabus will be submitted to the medical profession before being laid before the educational authorities. If progress is to be made there must be unanimity and co-operation among all sections of the profession.

I am, Sir, yours truly,

A FORMER LECTURER ON PATHOLOGY AND HYGIENE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—As I was prevented from attending the recent meeting held in the examination Hall under the auspices of the National Temperance League, I trust you will allow me a small space in your columns to say what I had hoped to say at the meeting. Any effort to promote the teaching of temperance to the rising generation cannot but receive the enthusiastic support of the medical profession. There can be no doubt that many drift unconsciously—through ignorance—into drunkenness. To be forewarned is to be forearmed, and it is our obvious duty to forewarn young people against the dangers of drunkenness, and to set clearly before them the advantages of temperance. This is the merest common-sense.

Granting the principle, how are we to put it into effective operation? Herein lies the difficulty. It is one thing to teach a truth, quite another thing to bring that truth properly home. Great care will be needed in formulating an effective scheme of temperance teaching. Anything of the nature of formal addresses, or physiological explanations illustrated by horrible diagrams, will but serve to disgust and bewilder the child mind, making a mystery and a difficulty out of what is after all a very simple matter. The subject must be taught in a simple, conversational way—the teacher should chat with the children about it, and endeavour to excite in them an active, intelligent interest in it. If boys of the working classes were told, *e.g.*, that the chief reason the alien pushes the British workman out of the labour market is because the former is sober, while the latter is but too often drunken, surely the damning fact would not fall altogether on deaf ears, but would appeal to the pride and common-sense of many. Again, the insistence of the monetary and material advantages attaching to temperance would not be without effect. Many a working man thinks nothing of spending sixpence a day on alcohol, and this, if saved, would in ten years time amount at low interest to more than one hundred pounds. I venture to think that a knowledge of this would deter many a young man from squandering his hard-earned money on a dangerous and unnecessary luxury.

It is from teaching conducted on such lines that I should expect to get the most satisfactory results, and I sincerely hope that due care will be taken in drawing up a suitable plan of instruction for the guidance of teachers.

I am, Sir, yours truly,

HARRY CAMPBELL.

Wimpole Street, W.

THE ALCOHOL QUESTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It seems strange that the views entertained

by the Profession some years ago on the value of alcohol in the treatment of disease should have changed as they have; and as you referred to in your leader of this week.

It is natural for the public to look to the Profession for guidance when any questions arise that have to do with alcohol. It is important to recognise clearly the difference between alcohol and the fluids which are used in various countries as common beverages, and which have undergone the peculiar and interesting process of fermentation. Alcohol is a definite hydrocarbon, far more easy to deal with than the complicated and varied liquids which produce it when fermented. The simple fact that alcohol will stop fermentation is enough to make us very careful how we observe or experiment, if we are to escape the consequences of feeble theories and the injuries they may bring with them.

I am, Sir, yours truly,
R. L.

THE ADMINISTRATION OF THE MIDWIVES ACT, 1902.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The Liverpool City Council has appointed its Health Committee to act as the "Local Supervising Authority," under the above Act, and the latter body has passed the following resolution:—

"That in cases of urgency in which medical practitioners have been called in by certificated midwives, as contemplated by Rule 17 of the Rules issued by the Central Midwives Board, pursuant to Section 3, subsection 1 of the Midwives Act, 1902, a fee of not exceeding one guinea be paid—on the certificate of the Medical Officer of Health, to each such medical practitioner in the event of his failing to obtain payment of the fee from the patient or from the Poor-law authority."

The resolution is somewhat ambiguous. For instance, the fee is not one guinea, and therefore a fee of 5s. may be paid! Again, the medical practitioner must prove to the Medical Officer of Health that neither the patient nor the Poor-law authority will pay the fee! Also, this fee is to entirely cover any difficult obstetric operation, or, merely one visit. I would suggest that a fee varying from 21s. to 44s. be paid by the L. S. Authority for an obstetric operation; and a 5s. day and a 10s. night visit for an ordinary visit. One must ask: If the agent of the Local Supervising Authority advise that a practitioner be called in, is their agent or authority responsible for payment of the fee? I do not think either the agent or the authority is—because Rule 17 of the Rules of the Midwives Board states only that in certain cases "a midwife must decline to attend alone, and must advise that a registered medical practitioner be sent for." Again, in Rule 19 (b) nothing is said regarding payment! It simply states that a woman "requires medical assistance at once on account of ———." "Signed — Certified Midwife." In fact, it is careful to avoid making any request for the practitioner to attend, or promise to pay.

I think every practitioner should carefully study these official Rules. A copy can be obtained from Spottiswoode and Co., New Street Square, London. Price 7d.; and the Midwives Act for 2d.

It is welcome news to find that after many years of fight by a few of us, the London Obstetrical Society has ceased to hold any examination, or to grant any certificate to midwives. Also that Dr. Cullingworth has retired from the Central Midwives Board.

I am, Sir, yours truly,

ROBERT R. RENTOUL.

Liverpool, March 31st, 1905.

THE CHINA CUP OF CHEERINESS AND COMFORT.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I am glad to find from your note last week that China tea is again coming into fashion. Unfortunately

for me, I am old enough to remember when tea was reckoned somewhat of a luxury to be drunk sparingly, and certainly the diseases grouped under the title of neurasthenia were not so common then as now. It was a lucky day for India and Ceylon, but an unfortunate one for the digestion of the people of these Islands, when it was discovered that the tea plant which is indigenous in China could be grown on other soils—but the infusion from the leaf is no more like the delicate flavour of good Pekoe than Californian claret resembles the juice of the grapes of the Gironde.

I am, Sir, yours truly,

MEDICUS.

April 2nd, 1905.

Literary Notes and Gossip.

MESSRS. DUNCAN FLOCKHART AND Co., the well-known manufacturers of chloroform and other anæsthetics, have compiled a bibliography relating to chloride of ethyl, "in the hope that it may be found useful to those members of the medical profession who are interested in this comparatively new general anæsthetic." This "Bibliography" is issued in neat pamphlet form, and we are asked to announce that the publishers will send it post free to medical men on application.

* * *

BISHOP PEREIRA'S little manual on "Intemperance" is one of a series of Handbooks for the Clergy. It aims at presenting to the clerical mind something of the magnitude of intemperance and the relation of the Churchman in undertaking measures to insure its prevention and arrest. There is a chapter on the medical aspect which, however, fails to grasp the true psychophysiological nature of the malady. The author would have done well to have associated himself with some medical expert in dealing with the more particularly medico-sociological portions of his subject. The publishers are Messrs. Longmans, Green, and Co.

* * *

We have received an interesting pamphlet entitled "The Infectivity and Management of Scarlet Fever," written by Dr. W. T. Gordon Pugh, and published by Messrs. J. and A. Churchill. It supplies a number of useful facts and figures relating to this disease, and deals especially with the vexed question of isolation as a means of checking the spread of infection. The pamphlet is deserving of a wide circulation.

* * *

AMID the prodigal output of cheap and trashy literature it becomes a pleasure to welcome something that is cheap and good from an educational point of view in Harmsworth's new "Encyclopædia." What *The Times* achieved recently for the wealthy by its recent issue of the "Encyclopædia Britannica," the Amalgamated Press and Messrs. Thos. Nelson and Sons are now doing for the masses by the publication in fortnightly parts of a work that should satisfy all but the most exacting critic. We have now before us the first three parts of this work which is to be completed in forty numbers of 160 pages at sevenpence. Each of these parts contains coloured maps and numerous other maps and illustrations which alone are worth the nominal sum asked, whilst the descriptive text is succinct, yet ample for all purposes, and so far as we are able to judge by the instalments before us, a scholarly and reliable work of reference is assured at a figure hitherto considered unattainable. We bespeak for the enterprise a cordial welcome and are confident the public will accord to it the full measure of appreciation its merits undoubtedly deserve.

* * *

DR. JOHN C. THRESH, Lect. Pub. Health, Lond. Hosp., and Dr. John W. H. Eyre, M.D., F.R.S., Lect. Bacteriol. Guy's Hosp., having conducted an investigation in order to determine the germicide strength of "Fels-Naptha," ten germs were selected for the purpose:—*Bacillus anthracis*, *B. pestis*, *B. typhosus*, *B. dysenteriae*, *B. coli*, *B. diphtheria*, *Vibrio cholerae*,

Vibrio Metschnikovi, *Staphylococcus pyogenes aureus*, and *streptococcus pyogenes longus*. Preliminary tests were made with a saturated solution of 10.3 per cent., the result being that seven cultures were sterilised in 2½ minutes; three were not; but all ten were sterilised in 15 minutes. In order to furnish a standard of comparison, further experiments were conducted with a 1 per cent. solution of phenol alongside of the eight Fels-Naptha solutions, the conclusions arrived at by these authorities being that the 1 per cent. solution of phenol sterilised the other cultures in 15 minutes, but failed to sterilise *staphylococcus aureus* in that time. It sterilised none in 2½ minutes, the 75 per cent. Fels-Naptha solution has therefore distinctly higher germicide strength than the 1 per cent. phenol. These results and the methods employed are fully tabulated in a pamphlet now before us, which those specially interested will doubtless be glad to consult.

Obituary.

D. A. M. TALBOTT, M.R.C.S.ENG., L.S.A.

We regret to record the death of Mr. Talbott, M.R.C.S. L.S.A., of Clifton, who was widely known for the great personal interest he took in the Bristol work of the Royal Humane Society, and for his forty years work in Bristol. He continued in practice until quite recently, but for several days had been ailing, and his illness ended with unexpected suddenness. He will be much missed and sincerely regretted. He was seventy-four years of age, and leaves a widow but no children.

LT.-COL. H. W. A. MACKINNON, R.A.M.C.,
M.R.C.S.ENG., L.S.A.

LIEUT.-COL. H. W. A. MACKINNON, late of the Army Medical Service, died last week at Weybridge at the age of sixty-three. He was educated at King's College, London, and qualified as a member of the Royal College of Surgeons, London, in 1864. He entered the medical service of the Army in October, 1865, and took part in the Egyptian Expedition of 1882, when he was present at the battle of Tel-el-Kebir and was slightly wounded. For his services in this campaign he was mentioned in despatches, and for the Burmese Expedition of 1885-6. He was promoted to be brigade surgeon in March, 1892, and retired in October 1895.

ROBERT W. J. EVANS, L.R.C.P. AND S. ED.

We regret to announce the death last week of Dr. Robert William Jonathan Evans, Medical Officer of Health for Wrexham, from a painful malady. He was oldest practitioner in the town, and had been medical officer of the borough since 1881. His annual reports were always of a most informing character. He had a genial presence, and took much delight in sport, and will be missed by a large circle of friends.

THOMAS CHAS. LAW, L.R.C.S.ED.

THE death is announced, at Padiham, of Mr. Thomas Charles Law, L.R.C.S.E., who only retired a fortnight ago, after fifty years' work as a medical practitioner. He was seventy-four years of age. During the great cholera epidemic at Glasgow in the winter of 1853-4 he was appointed the head of the night staff. He went to Padiham in March, 1854, and had been the factory surgeon ever since. He was also Poor-law medical officer.

THOMAS MORTON, M.D.

THE death of Dr. Thomas Morton, brother of the town clerk of Kidderminster, has removed a notable physician. The deceased gentleman was an M.D. of London University, and was in practice for over forty years, and was president of the well-known Harveian Society. His wife was a daughter of the well-known antiquary Mr. Toms, the founder, and for many years editor, of "Notes and Queries." A son is a gold medallist, and a daughter holds a high position at Bedford College, London.

Stewart Institution—Hospital for Mental Diseases.

We have received a copy of the new edition of the prospectus of this hospital, situated at Palmerston, Chapelizod. It is a branch of the Stewart Institution for Imbecile Children whose valuable work since its foundation in 1869 is now so well-known. The prospectus is copiously illustrated with photographs, by Mr. Wm. Lawrence, of the interior accommodation afforded by the fine buildings, as well as of many beautiful views in the grounds by which they are surrounded. The letterpress is very interesting, and the whole production goes far to show that Ireland can offer accommodation for the mentally afflicted of a most comfortable and elegant character, fully equal to anything of the kind to be found in England or Scotland, thus rendering it unnecessary for so many patients being sent to these places for treatment, as has so long been the case. The reproduction of the photographs may be said to be in the highest style of art. The printing, executed on the best art paper by Mr. Falconer of Upper Sackville Street, is of a very finished description, and quite sufficient to show with what excellence work of the kind can be turned out by a Dublin firm. Altogether, we can strongly commend this prospectus to the notice of the medical profession and others interested in providing for insane patients. Copies can be had on application to the office, 40, Molesworth Street, Dublin.

The West London Post Graduate College.

A SUCCESSFUL conversation was given by the staff of the Post Graduate College, West London Hospital, on March 29th, 1905. The spacious out-patients' hall and consulting rooms were completely transformed for the occasion, providing ample accommodation for the large number of guests and members of the college that had assembled. The company was received by the Dean, Mr. L. A. Bidwell, F.R.C.S., and various entertainments in the shape of animatograph displays, demonstrations of colour photography, etc., were provided during the course of the evening. Especially to be noticed was the excellent and instructive selection of pathological specimens and microscopic sections from the pathological laboratory of the hospital, exhibited by Dr. J. P. Candler. The selection of music given by Mr. Algernon Clarke's Orchestra at intervals was much appreciated. A very pleasant evening was spent by those who thus partook of the lavish hospitality displayed by the hospital and college staff.

University of Glasgow.

At the recent professional examinations for the degrees of M.B., Ch.B., of this University, the following candidates passed with distinction in the subjects indicated:—

First Examination—In botany, zoology, physics, and chemistry—John Allan. In zoology and physics—John Allan, Munro Cameron, James Lachlan Ure. In zoology and chemistry—William M'Adam, M.A. In zoology—Charles Duguid, John William M'Nee, William Wilson Rorke, Robert Sweet, Douglas Young. In physics—Jessie Deane Rankin, Margaret Eason Robertson, Neil Campbell Scott, William Wilkie Scott, James Johnston Sinclair, James Stewart Somerville, Alexander Stewart. In chemistry—Morris William Broudy, David Neilson Knox, John Park Mathie.

Second Examination.—In anatomy and physiology—Walter Hermann Kiep, Matthew Young. In physiology and in materia medica and therapeutics—Matthew John Stewart. In anatomy—James Hogg Martin. In physiology—Wallace Wright Adamson, Leonard John Dunstone, William Cooper Gunn, Andrew James Hutton, Hugh Morton, John Stewart M.A.; Hugh Johnstone Thomson, William Barrie Watson. In materia medica and therapeutics—Thomas Hay Campbell, James Robert Craig.

Third Examination—In pathology and in medical jurisprudence and public health—William Gilfillan, Alfred Cecil Sharp. In pathology—William Rome Cammock, Peter Mitchell, M.A., Thomas Baillie Smith. In medical jurisprudence and public health—Charles Burns, Robert Marshall, Agnes Picken, M.A.

In the third professional examination for M.B.,

C.M. (old regulations), Robert Stewart M'Kim, M.A., passed with distinction in pathology.

Royal Colleges of Physicians and Surgeons of Edinburgh and the Faculty of Physicians and Surgeons of Glasgow.

At the Quarterly Examinations of the conjoint Board, held in Edinburgh, which concluded on the 18 inst., the following 24 candidates passed the Final Examination out of 45 entered, and were admitted L.R.C.P.E., L.R.C.S.E., and L.F.P. and S.G.:—Wilmot Alvin Graham, Toronto; James Walsh, County Waterford; Sybil Lonie Lewis, Chester; Alfred Harold Singleton, Ontario; James Bartholomew Mears, Tynemouth; Archibald McKendrick, Kirkcaldy; Elizabeth Matilda Elderkin Kerr-Harris, Sydney; Frederick William Green, Nova Scotia; Sohrab Shapurji Antia, Central India; William Latta Robertson, Dundee; Duncombe Steele Steele-Perkins, Exeter; George William Craig, Birmingham; William Montgomery Johnston, County Derry; Ayodeji Oyejola, West Africa; Henry James Duff Davidson, Canada; Edward Herrick Knowles, New South Wales; Alexander Thomas Munroe, Canada; Edgar Rae Frankish, Canada; Charles Henry Keegel Scharenguevil Ceylon; Simon Samuel Sperber, Austria; Mian Kedar Nath Sing Culeria, Punjab; Gideon Hendrik van Zyl, Cape Colony; Ardeshir Cowasji Dhondy, Bombay; and Henry Edward Bolton, Ireland; and two passed in medicine and therapeutics, four in midwifery, and three in medical jurisprudence. Ten other candidates passed the first seven passed the second, and ten passed the third examinations at the same meetings of the Board.

Royal College of Surgeons in Ireland.

Prize List, Winter Session, 1904-1905.

Descriptive Anatomy—Junior—G. C. Sneyd, first prize (£2) and medal; R. Adams, second prize (£1) and certificate.

Senior—H. W. White, first prize (£2) and medal; J. Murray, second prize (£1) and certificate.

Practical Anatomy—First Year—Miss I. M. Clarke, first prize (£2) and medal; C. Greer, second prize (£1) and certificate.

Second Year—G. S. Levis, first prize (£2) and medal; G. W. Stanley, second prize (£1) and certificate.

Practice of Medicine.—L. Lucas, first prize (£2) and medal; J. Prendiville, second prize (£1) and certificate.

Surgery—L. Lucas, first prize (£2) and medal; C. H. Wilson, second prize (£1) and certificate.

Midwifery—J. Prendiville, first prize (2£) and medal; G. M. Loughnan, second prize (£1) and certificate.

Physiology—A. E. S. Martin, first prize (£2) and medal; G. S. Levis, second prize (£1) and certificate.

Chemistry.—R. H. F. Taaffe, first prize (£2) and medal; R. Adams and Miss I. M. Clarke (equal), second prize (£1) and certificate.

Pathology—G. F. Shepherd, first prize (2£ and medal); C. J. Hare, second prize (£1) and certificate.

Physics—R. Adams, first prize (2£) and medal; Miss I. M. Clarke, second prize (1£) and certificate.

The lectures and practical courses of the Summer Session commenced on Monday April 3rd.

The Epidemic of Typhoid Fever in Lincoln.

THE total number of notifications during the week ending Friday, March 24th, was thirty-two, showing a further decline of the epidemic, forty-six cases having been notified in the previous week.

Trinity College, Dublin.

THE following candidates for the Diploma in Public Health, passed Part I.:—Robert J. Fleming, Douglas S. B. Thomson.

The following passed Part. II. at Hilary Term, 1905: Thomas F. Griffin, Douglas S. B. Thomson.

Conjoint Examinations in Ireland.

CANDIDATES have passed the first professional examination as undernoted:—R. H. F. Taaffe (with honours), P. N. Allman, H. F. Blood, B. W. Farrell, C. Greer, W. Mulcahy, G. C. Sneyd, P. Reardon.

The following have completed the above examination:—A. J. M. Blake, B. G. S. Bolas, L. S. O'Hare, Miss Nora Williams, O. H. Woods.

Notices to Correspondents, Short Letters, &c.

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

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 re-forwarding 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.

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.

DIPLOMA.—The question of petitioning Durham University to reduce the waiting years for the M.D. from 15, to, say, 7 or 5 and the minimum age from 40 to 30 years has been frequently raised, but no definite action, as far as we know, taken.

DR. FORBES WOLFE'S interesting case is marked for early insertion.

DR. J. BEARD (Edinburgh).—Your communication arrived too late to be dealt with in our present number.

DR. A. D. (Lincoln).—We quite agree about the overcrowding of the out-patient department. The Birmingham Free Hospital for Sick Children is trying the experiment of limiting the number of new cases on any one day to 65, though patients coming with a recommendation from a medical man are always seen.

DR. G. F. M.—Is thanked, the matter being of great interest to the profession.

SUBURBAN PRACTITIONER.—(1) Munro's Manual of Medicine. (2) Treves' or Allingham's small Operative Surgery. (3) Mummery's After-treatment of Operations.

MORE COMING.

It is reported that a young married man of Golconda, wrapped in the greatest excitement, flew to the telegraph office of his town and wired his wife's relatives a happening as follows: "Twins to-day, more to-morrow."

STAFF.—As far as we can learn, most of the "startling cures" which appear in the daily papers are furnished to reporters by hospital porters and out-patients. Quite recently the name of a first-year student was given as that of the operator in a difficult surgical case.

G. P. (London).—The title "specialist" is often innocently earned, not sought. A patient, generally a lady, is cured of one particular disease by a consultant and she forthwith advertises him as such among her friends. This may possibly do him more harm than good, as it prevents patients going to a doctor, who, in the lay estimation, is only good for one disease.

M. O. H.—The question of the exact amount of responsibility of local superintending authorities regarding midwives is still under discussion with the Central Midwives Board.

DR. H. (Notts).—There are only three resident English doctors in Algiers. The one at the thermal station at Hamman R'hira is a Frenchman. The season there practically ends in April.

WELSH DOCTOR'S HANDWRITING.

The Chairman of the Festinlog Guardians (Mr. Owen Jones) after an almost ineffectual attempt to decipher a letter written by a medical man, said the handwriting of the doctors of North Wales was execrable. He did not know of more than one doctor who might be described as writing a truly legible hand. He thought handwriting should be one of the qualifying subjects.—(Laughter.)

DR. A. F. A.—We regret that we are unable to accede to your request; our list being already too full has been recently reduced.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, APRIL 5th.

OBSTETRICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Dr. A. H. N. Lewers, Dr. H. R. Andrews, and Dr. Boxall. Short Communication:—Mr. J. H. Targett: Hysterectomy for Severe Concealed Accidental Hæmorrhage. Paper and Epidiascope Demonstration: Dr. C. Dockery: The Development and Retrogression of the Corpus Luteum, with special reference to the Compound Lutein Cystomata found in Association with Vesicular Mole and Chorio-epithelioma.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (23 Chancery Street, W.C.).—4 p.m. (Mr. R. Harrison: Clinique. (Surgical.) 5.15 p.m. Mr. H. L. Barnard: Gastric Surgery.

CENTRAL LONDON THEATRE AND EAR HOSPITAL (Gray's Inn Road, W.C.).—5 p.m. Demonstration: Dr. D. Grant: Larynx.

THURSDAY, APRIL 6th.

CHILDHOOD SOCIETY AND THE BRITISH CHILD STUDY ASSOCIATION (Parkes Museum, Margaret Street, W.).—8 p.m. Lecture: Dr. A. Rabagliati (Bradford): The Health of Children *qua* Food and Management. Arranged by the British Child-Study Association.

ROSTKEN SOCIETY (20 Hanover Square, W.).—8.15 p.m. Exhibition of Novel Apparatus.

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

ROYAL COLLEGE OF PHYSICIANS OF LONDON (Pall Mall East).—5 p.m. Dr. L. E. Hill: The Influence of Atmospheric Pressure on Man. (Oliver-Sharpes Lecture.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (23 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Sir Patrick Manson: Some Recent Advances in Tropical Pathology.

FRIDAY, APRIL 7th.

LARYNGOLOGICAL SOCIETY OF LONDON (20 Hanover Square, W.).—5 p.m. Cases will be shown by Mr. Tilley, Mr. Pegler, Mr. Robinson, Mr. de Santi and others.

WEST KENT MEDICO-CHIRURGICAL SOCIETY (Royal Kent Dispensary, Greenwich Road, S.E.).—8.45 p.m. Discussion on Radiotherapeutics (opened by Dr. F. H. Low).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (23 Chancery Street, W.C.).—4 p.m. Mr. M. Yearley: Clinique. (Bar.)

Vacancies.

East London Hospital for Children and Dispensary for Women (Shadwell, E.).—Medical Officer for the Casualty Department. Salary £100 per annum. Luncheon provided at the hospital. Applications to Thomas Hayes, Secretary.

York Dispensary.—Resident Medical Officer. Salary £120 per annum, with board, lodging, and attendance. Applications immediately to W. Draper, Esq., De Grey House, York.

Herefordshire General Hospital.—House Surgeon. Salary £100 per annum, with board, furnished apartments, and washing. Applications to W. A. W. Price, Secretary.

City of London Hospital for Diseases of the Chest, Victoria Park.—Pathologist. Salary £105 per annum, Applications to Henry T. Dudley Ryder, Secretary.

Cumberland and Westmorland Asylum, Garlands, Carlisle.—Junior Assistant Medical Officer. Salary £120 per annum, with board, lodging and washing. Applications to the Medical Superintendent.

Ebbw Vale Workmen's Doctors' Fund.—Hospital Surgeon. Salary £500 per annum net. Applications to Thomas J. Rees, Secretary, Victoria Monmouthshire.

Royal Dental Hospital of London (School of Dental Surgery), Leicester Square, W.C.—Jnr. Demonstrator of Practical Dental Surgery. Salary £100 per annum. Applications to the Dean.

Willenden Urban District Council.—Male Assistant Medical Officer. Salary £125 per annum, with board, washing, and lodging. Applications to Stanley W. Ball, Clerk to the Council, Public Offices, Dyne Road, Kiburn, N.W.

East Sussex County Asylum.—Assistant Medical Officer and Pathologist. Salary £175 per annum, with board, lodging, washing, and attendance. Applications to the Medical Superintendent.

County Asylum, Chester.—Third Assistant Medical Officer. Salary £160 per annum, with board, lodging and washing. Applications to Dr. Lawrence, County Asylum, Chester.

Birkenhead Union.—Resident Assistant Medical Officer. Salary £120 per annum, with board, washing, and apartments. Applications John Carter, Clerk to the Guardians, Clerk's Office, Poor Law Offices, Birkenhead.

Appointments.

CUNCLIFFE, T. V., M.D., B.S.Lond., Honorary Pathologist to the Oldham Infirmary.

DAVIS, O. C. M., B.Sc., Lecturer on Materia Medica and Practical Pharmacy at University College, Bristol.

GARDEN, W. SIM, M.B., Ch.B., Second Medical Officer of the County Asylum, Chester.

NEILD, NEWMAN, M.B., B.Ch.Vict., L.B.C.P.Lond., M.B.C.S., Lecturer on Pharmacology and Therapeutics at University College, Bristol.

Births.

MARTIN.—On March 30th, at 12 Oxford Square, W., the wife of Henry Charrington Martin, M.D.—a daughter.

WILSON.—On April 1st at 7, Ladbroke Square, London, the wife of J. H. Orme Wilson, M.D., of a son.

Marriages.

STEVENS-MCINTYRE.—On March 29th, at St. George's Hanover Square, Alfred Edward Stevens, M.D., youngest son of the late George Stevens, of Baling, to Alice Morice, youngest daughter of the late Archibald McIntyre, of Montreal.

Deaths.

MATTHEWS.—On March 31st, at Sudbury, Suffolk, of pneumonia, Alec Leslie Matthews, F.R.C.S., L.R.C.P., of the London Hospital, late of Norwood, age 81.

Original Communications.

CONSERVATIVE PERINEAL PROSTATECTOMY. (a)

By C. ARTHUR BALL, M.D.,

Assistant Surgeon, Sir Patrick Dun's Hospital, Dublin.

It will no doubt be conceded that the object in all surgical procedures should be to confer the maximum benefit on our patient consistent with the minimum amount of injury to the anatomical structures involved.

The methods of prostatectomy as usually performed by the suprapubic or perineal route cannot be regarded as ideal surgical procedures, for the prostate has to be removed largely by the sense of touch; hæmorrhage during the operation is not fully under control; and the amount of injury inflicted on the bladder, urethra, and ejaculatory ducts is frequently considerable.

Although excellent results frequently follow prostatectomy, some of us have seen trouble following the operation, such as incontinence of urine due to injury of the sphincters of the bladder and urethra; septic trouble spreading down the injured ejaculatory ducts to the epididymis and testicle; and persistence of a vesical fistula.

The question we have to decide is, Can the prostate, or rather a sufficient part of the prostate, be removed so as to cure the patient without inflicting permanent injury to important anatomical structures.

Perineal prostatectomy as performed by Dr. Young, of the Johns Hopkins Hospital, (a) seems to me to fulfil these conditions more fully than the methods previously advocated. I will therefore endeavour to demonstrate to you to-night the essential features of his operation of conservative prostatectomy.

To remove the prostate by the perineal route some method of traction is necessary to bring the prostate within easy reach. A suprapubic incision has been used to push the prostate down into the perineum; the only advantage this possessed over the suprapubic enucleation was the establishment of perineal drainage. The hooks, as used by Murphy in some cases, gave a good perineal exposure, but in others tore so readily through the prostate that they were of little use. Syms used an intra-vesical balloon; this overcame the great objection to perineal prostatectomy, but hardly gave sufficient strength for the necessary traction. Young's prostatic tractor has, he says,

transformed the operation of perineal prostatectomy for him. I have tried his instrument several times on the dead subject, and once on the living, and its use affords a view of the prostate such as I had not thought possible. The steps of the operation described by Young are briefly as follows:—

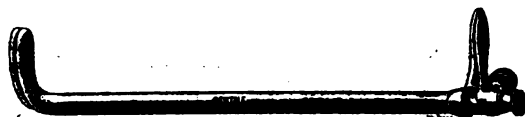


FIG. I.—Young's prostatic tractor, closed and ready for introduction.

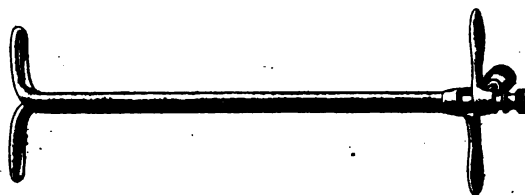


FIG. II.—Young's prostatic tractor, open.

Position of the Patient.—The patient is placed in the exaggerated lithotomy position, a grooved sound having previously been passed into the bladder as a guide to subsequent urethrotomy. If the patient is thin, and the prostate apparently close to the perineum, a median incision is made not more than 6 cm. long, the posterior limit being near the anus. The central tendon of the perineum, connecting the bulb in front and the levator and muscles behind, is exposed.

If the patient is a large man, with thick perineal muscles, and the prostate is found, on rectal examination, to be situated deep, or the peri-rectal fat is abundant, an inverted V-shaped incision is used; the apex of this incision is situated just over the posterior part of the bulb. The two branches are each 5 cm. long, the posterior limits being about midway between the anus and ischial tuberosities.

Exposure of the Membranous Urethra.—After the superficial muscles have been exposed by blunt dissection, the central tendon is caught by a clamp near the bulb and divided. This at once frees the sphincter and the levator ani from their anterior attachment, and exposes the rectum, drawn forward by the recto-urethralis muscle. The recto-urethralis is a short muscle with rather indefinite margins which, as its name implies joins the rectum with the urethra. It is apparently

(a) Read before the Surgical Section of the Royal Academy of Medicine in Ireland, Friday, January 13th, 1905.

responsible for the acute anterior flexure of the rectum which lies so close to the apex of the prostate and membranous urethra, and which one finds in rectal examinations. (Mr. F. Wood Jones [*b*] has found that the band of musculature which passes from the front of the rectum, to be lost in the tissue behind the membranous urethra, is a remnant of the recto-cloacal communication in the embryo.) In order to reach the membranous urethra and the apex of the prostate it is necessary to divide this muscle; this exposes the retro-prostatic space described by Proust, (*c*) who has shown that unless this muscle is divided the operator is apt to tear the rectum, which is drawn forward by it.

Division of this muscle allows the rectum to drop back, and leads at once into the space surrounding the posterior surface of the prostate.

Urethrotomy and Insertion of Tractor.—After the membranous urethra has been exposed, a retractor is inserted and the apex of the prostate brought into view. The membranous urethra is then opened on the sound, and the edges of the urethral wound caught up by silk sutures or Kocher clamps. A sound of moderate size is then passed through the incision into the prostatic urethra and bladder, and the sphincters dilated by a to-and-fro motion of this instrument. The prostatic tractor, closed, is then passed into the bladder, the edges of the urethral wound being held apart to facilitate its introduction. As soon as the beak is free in the vesical cavity the blades are separated. The instrument is now ready for whatever traction may be necessary to draw the prostate well down into the perineal wound.

Exposure of Prostate and Incision of Capsule.—Lateral retractors are so placed that with the posterior retractor drawing the rectum backwards, and the prostatic tractor drawing the gland outwards, a splendid exposure of the entire posterior surface of the prostate is obtained. An incision is then made on each side of the median line for almost the entire length of the posterior surface of the prostate, and about 1 cm. deep. The two lines are convergent, being about 1.8 cm. behind, and 1.5 cm. apart in front. The bridge of tissue which lies between them contains the ejaculatory ducts, and its preservation is of utmost importance if the integrity of these structures is to be left uninjured. It is for this purpose that the initial capsular incision is made 1 cm. deep on each side, as these define at once, and correctly, the width of the "ejaculatory bridge," and prevent its being torn, as might happen if we depend on blunt dissection. Another advantage is that these incisions bring us at once to the side of the urethra where the internal enucleation (urethra from inner surface of lobe) can be easily accomplished later on.

Enucleation of Lateral Lobes.—We are now ready to begin the external enucleation, the separation of the capsule from the lateral lobes, which is best done with the blunt dissector. Capsules are of varying thickness, and contain several layers of cleavage. It is important to start the separation in the right layer, not too deep, as you may be led into the substance of the lobe, and not so superficially as to be outside of most of the capsule. After the stripping-up process has been started correctly, it is easily continued by blunt dissectors until first the lateral and then the anterior surface of the lateral lobes have been

freed from the capsule. The internal enucleation should be taken up after the external, as it is a much more delicate procedure, and often requires considerable care to prevent tearing into the urethra. As remarked above, the primary incision is made with the scalpel until the level of the urethra is reached, after which the blunt dissector is used. During this procedure the shaft of the prostatic tractor is grasped firmly in the operator's left hand, and serves not only to draw the prostate so well down into the skin wound that every procedure is done in plain view, but to steady the prostate and mark out the course of the urethra so that it can be avoided. When the enucleation of a lateral lobe has progressed fairly well on each side, it is advantageous to have traction made on the lobe itself in order to facilitate the separation of the deeper portion. The special forceps designed by Dr. Young is here of great assistance, as with it great traction can be applied without tearing the lobe, thus facilitating the deeper enucleation.

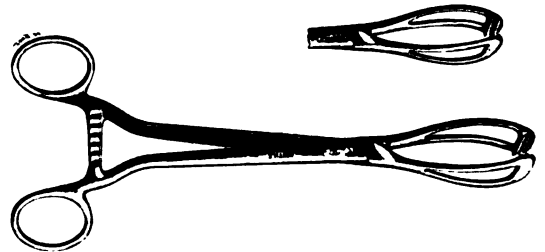


FIG. VII.—Young's lobe forceps.

Nearly all the enucleation is done with the blunt dissector, but when the intra-vesical portion of the lateral lobe is reached the finger should be used to avoid tearing through the thin mucous membrane covering it. The intra-vesical blade of the prostatic tractor, which can be distinctly palpated through the mucous membrane by the enucleating finger, serves to direct the separation of the deeper portion, and warns against tearing into the bladder. It also shows when some of the lobe has been left behind.

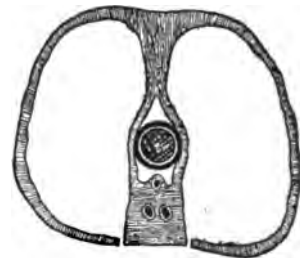


FIG. VIII.—Schematic cross-section after enucleation of lateral lobes, showing ducts and median bridge of tissues. Instrument in urethra.—(Young.)

Enucleation of the Middle Lobe.—After the lateral lobes have been shelled out, attention should be directed to the median portion of the prostate. When there is more or less hypertrophy of the prespermatic group of glands, the mass may be easily seen or felt by the finger in one of the intra-capsular cavities. The median enlargement is generally more or less definitely attached to one or both of the lateral lobes, and is often already so loosened from its encapsulations that

there is no difficulty in shelling it out through one of the lateral cavities, without disturbing the integrity of the ejaculatory ducts and prostatic tissue immediately surrounding them. The tractor can be used to depress the middle lobe and draw it down, so that pushing against it with the index finger of the left hand, which has been inserted in the right intra-capsular cavity, it can be grasped with the forceps and rapidly enucleated. By this technique Dr. Young has been able to remove median lobes of considerable size without destroying the ejaculatory ducts.

Drainage.—Before withdrawing the tractor, a careful examination should be made by inserting the finger into both lateral cavities and palpating the blades through the vesical mucosa, in order to determine that no important glandular mass has been left behind. Abundant vesical drainage should be provided, as a small tube may easily become plugged by blood clots, and give great annoyance afterwards. Dr. Young now uses two tubes, one a small catheter, the other an ordinary tube about 1 cm. in diameter. These are fastened together by ligatures at four places, about one inch apart, and are prepared before the operation, so that as soon as the tractor is withdrawn they can be inserted into the urethra and bladder. The catheter is immediately connected with a tank of normal salt solution, and the bladder thoroughly washed clean of blood. After the tubes have been properly adjusted they are tied by a heavy silk suture to the skin at the upper angle of the wound. The lateral prostatic cavities are then firmly packed with gauze, and additional packing is placed in the retro-prostatic space.

The wound is closed by deep catgut sutures, and if the inverted V incision is used one side is completely closed, the other is left open at the upper part for the tube and gauze.

After Treatment.—Continuous irrigation of the bladder is kept up if the patient has cystitis (and most have), often for a week, with great benefit to the vesical inflammation.

A submammary infusion of 1,000 c.c. salt solution is given either on the operating table or after the return to bed. This is considered so valuable, both as a preventive to shock and anuria, and as a cure for post-operative thirst, that it is never omitted.

The patient is generally kept in bed a week, when the drainage-tubes are withdrawn. The gauze drains are loosened on the second day and gradually withdrawn, all of the original being out by the sixth day. On the ninth day, after passing a sound, a small catheter is inserted through the meatus into the bladder, and held in place by straps. Permanent drainage is thus maintained for five days, the bladder being irrigated twice daily with boric solution. When the catheter is withdrawn, a good portion of the urine will be found to come through the perineum, but in a short time almost all will come through the meatus, though it is sometimes five or six weeks before the minute perineal fistula closes.

Dr. Young kindly informs me (Jan. 3rd, 1905) that he has now performed his operation of perineal prostatectomy on some 75 cases, and he reports as follows:—"There have been no deaths attributable to the operation. Three patients have died since the operation, one 85 years of age, five weeks after of other causes; one two weeks after of pulmonary embolism; and the third, who was in a chronic condition of uræmia and

had received little benefit from prolonged catheter treatment, two weeks after the operation, and the autopsy showed greatly dilated ureters and kidneys, so that nothing could have saved him.

"The results have been splendid, full power of micturition being established and perfect continence given. In only two or three cases has a perineal fistula persisted, and these from lack of after-treatment.

"I am glad to say that the results as to the preservation of sexual power have been fully borne out, the great majority of those who had unimpaired sexual power before the operation being preserved in the manly vigour after operation."

The following is my personal experience of perineal prostatectomy:—

CASE I.—Patient, a man, æt. 64, was admitted to Sir Patrick Dun's Hospital, July 19th, 1904, complaining of frequent passage of water, stating that for the last two years he had passed water every quarter of an hour day and night, except one night fourteen months ago, when he drank too much, with the result that he was three weeks in hospital in the country. This was the only occasion on which he had retention of urine. Asking him if he got up every quarter of an hour at night to pass water, he replied, "If I did not I would be dead long ago."

On Examination.—He was a fine, strong-looking old man. His urine contained some pus, but the cystitis present was only slight. He passed water frequently, about one ounce at a time; residual urine, half an ounce. He had no difficulty in passing water, and washing out the bladder it was impossible to get him to retain two ounces of fluid, thus giving the idea that he had a contracted bladder, a very unusual symptom of prostatic enlargement. His urethra did not admit the passage of the cystoscope, and with the small capacity of the bladder it would have been risky. Per rectum the prostate was considerably enlarged, hard, and not tender to the touch.

I decided to perform perineal prostatectomy, and having just heard of Dr. Young's operation thought it would be a nice thing to leave the urethra and ducts intact, but unfortunately I had not full particulars of the operation.

On July 25th, using a sound to depress the prostate, and making bilateral capsular incisions, I enucleated the lateral lobes, with the aid of Murphy's hooks. Before proceeding very far I found the sound exposed in the wound, and that the urethra had to a large extent come away with the prostate, and the torn ends of the ejaculatory ducts were seen in the wound. A drainage-tube was placed in the bladder, and the wound partially closed, the cavity round the tube being plugged with gauze.

The patient was very well for the first few days following the operation, the drainage-tube being removed on the fourth day.

Nine days after the operation the right epididymis was swollen and very painful, and the patient's temperature began to rise; this trouble made two or three attempts to subside, but gradually increased and one week later the right testicle was greatly swollen and the skin adherent over it, and as the fever had increased an incision was made into the swelling: very little pus escaped and the testicle seemed necrotic.

During this time the perineal fistula was rapidly closing, and fifteen days after the operation urine was passed per urethram for the first time. As the

bladder became more distended, a certain amount of hæmorrhage into it took place; this recurred on several occasions, being apparently due to the stretching of some granulating surface: it was finally stopped by injecting the bladder with a weak adrenalin solution.

Four weeks after the operation the left epididymis became affected; this, however, subsided after some days. The right testicle continued to suppurate, and finally the greater part came away as a slough. This complication, due to sepsis spreading down the injured ducts, reduced the patient's strength to a marked degree, and for a time I was very uneasy about him. After the separation of the slough he began to improve steadily, and when he left hospital he was passing water naturally every two hours during the day, and at night he sometimes slept for four hours at a time.

Septic trouble spreading down the injured ejaculatory ducts seems to be a fairly common complication. Petit (*d*) reports that 12 cases in 30 suffered from epididymitis after perineal prostatectomy.

The fact that I nearly lost this patient owing to this complication has made me determined in future cases to respect the ducts and avoid their wilful injury.

CASE II was that of a patient, æt. 63, who was admitted to Sir Patrick Dun's Hospital on December 5th, 1904, suffering from a large inguinal hernia, which had been strangulated for twenty-four hours. I was sent for to operate. The hernial sac contained the cæcum and vermiform appendix, and it was necessary to slit up the external and internal oblique muscles in order to reduce the mass. He made a good recovery. The only trouble he had was from his bladder; he passed water very frequently, and complained of pain towards the end of micturition. The urine contained an enormous quantity of pus. A gum-elastic catheter was passed five days after the operation, and about one ounce of very foul-smelling pus withdrawn. His bladder was washed out daily with boric lotion, which, with urotropin internally, slightly improved the cystitis. He stated that his bladder trouble began six years ago with retention of urine. For the last four years, acting on the advice of his medical attendant, he has passed a catheter on himself every evening. For the past six months he has had severe pain towards the end of micturition, most severe after the passage of the catheter, and has had to pass water almost every hour.

On rectal examination the prostate was considerably enlarged and tender, and came unusually low down, so that, in spite of its enlargement, the seminal vesicles could be easily felt.

Although old and feeble-looking, he made such a good recovery from the strangulated hernia that I thought his kidneys were not at any rate seriously affected; and as he was anxious to have something done to relieve his prostatic trouble, I performed a perineal prostatectomy on December 19th, a fortnight after the hernia operation.

The operation was carried out in the manner I have just described. By means of the tractor the prostate was so well exposed that the use of retractors was unnecessary. The right lateral lobe was much larger than the left and was enucleated first. Both lateral lobes were easily removed without injuring the ejaculatory ducts

or the mucous membrane of the bladder, but I, to some extent, injured the prostatic urethra in one place by what was probably the unnecessary use of a scissors. A small median enlargement was then enucleated through the left lateral cavity. It was unfortunately now found that the bladder contained calculi. Three in all, polished and faceted, were removed; the two larger were one inch in diameter, and their removal was difficult, and spoiled the carefully preserved urethra.

Had I examined the bladder with the cystoscope, or even with a metal instrument before the operation, I would, I think, not have attempted conservative prostatectomy, but would rather have done a median lithotomy, and enucleated the prostate through the prostatic urethra. But owing to the recent hernia operation, and the irritable condition of the patient, I was anxious to avoid examining him more than was absolutely necessary. The slight loss of blood during the operation was very striking, practically the only hæmorrhage taking place during the extraction of the calculi.

The patient stood the operation well; continuous irrigation of the bladder was kept up for six days, when the tubes were removed.

His progress continued satisfactory, and he was up for the first time two weeks after the operation; three days later vomiting and fever set in; the wound presented a healthy, granulating appearance, and nothing was found to account for his symptoms, which, after four days, seemed to be subsiding, his temperature having fallen to 99°; it rose again the same evening to 100°; the next morning it reached 103°, the pulse 120°. A careful examination of the wound and bladder again revealed nothing to account for his condition. Urine apparently free from pus flowed through the fistula; the temperature and pulse increased, and he died the following morning, twenty-three days after the operation, his temperature just before death being 105·8°. Unfortunately, no autopsy was possible.

The sudden onset of secondary septic trouble so long after the operation, and with the satisfactory condition of the bladder and wound, must be considered an unusual and unfortunate occurrence.

These two cases have impressed me with the fact that the operation of conservative prostatectomy is not more difficult than the ordinary perineal operation, and with practice should be done almost as quickly.

Now that prostatectomy is being done in younger men, the fact that the powers of procreation have not been destroyed may often mean a great deal to the patient and his next-of-kin.

In conclusion, I wish to thank Dr. Young for furnishing me with particulars of his work, and for the many things I learnt from him while at the Johns Hopkins Hospital; also Mr. E. H. Taylor for placing the above two cases at my disposal, and for very valuable assistance and advice during the operations.

Since writing the above paper I have had an opportunity of performing perineal prostatectomy on a patient, æt. 75. He is now, four weeks after operation, passing water naturally at three hour intervals.

(a) Young: *Journal of the American Medical Association*, October 24th, 1903.

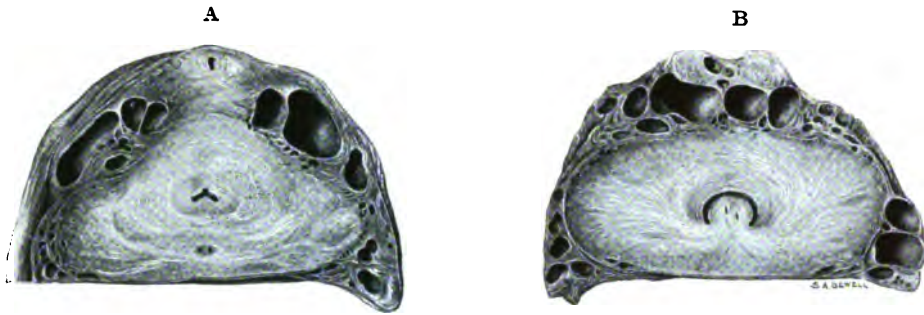


FIG. III.—A and B are drawn actual size from sections through the prostate of a formalin hardened subject kindly lent by Prof. A. F. Dixon.

A. A short distance below the bladder floor.

B. Just above the opening of the ejaculatory ducts into the prostatic urethra.

The large veins in the capsule of the prostate are well shown and explain the occurrence of pulmonary embolism after prostatectomy. Note the way the large vessels are confined to the anterior and lateral aspects of the capsule. The prostatic urethra is seen in the centre of each section. In A, note the position of the ejaculatory ducts, lying close to one another, in the middle line near the posterior surface of the capsule. In B, the ducts are seen piercing the veru montanum to open into the urethra.

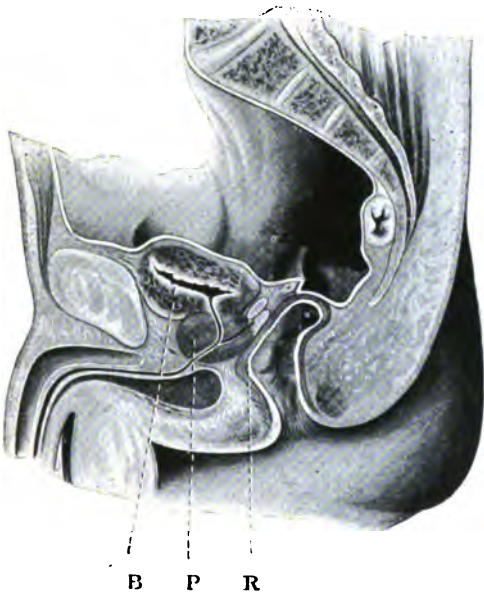


FIG. IV.—Cast of a mesial section through the pelvis of a formalin hardened subject (Prof. A. F. Dixon), showing the acute anterior flexion of the rectum where it is drawn forwards by the recto-urethralis muscle.

R Rectum. P Prostate. B Bladder.



FIG. V.—Showing position of blades in interior of bladder in case of median and bilateral hypertrophy (Young).

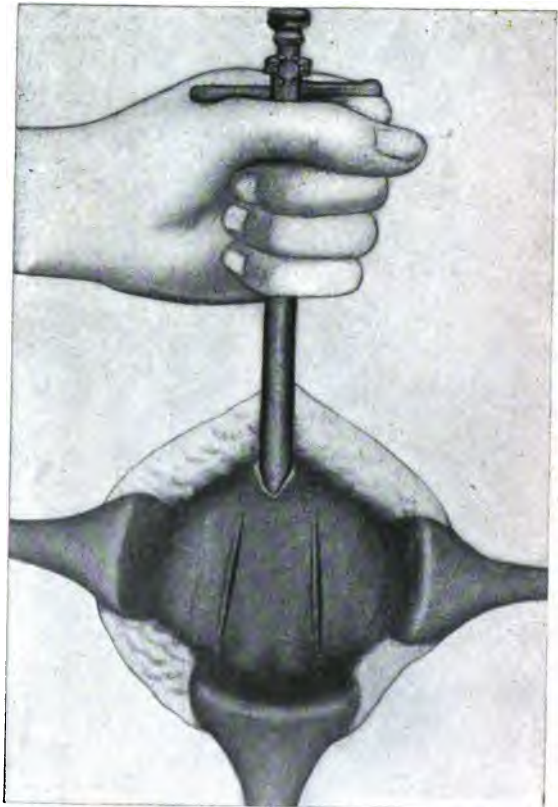
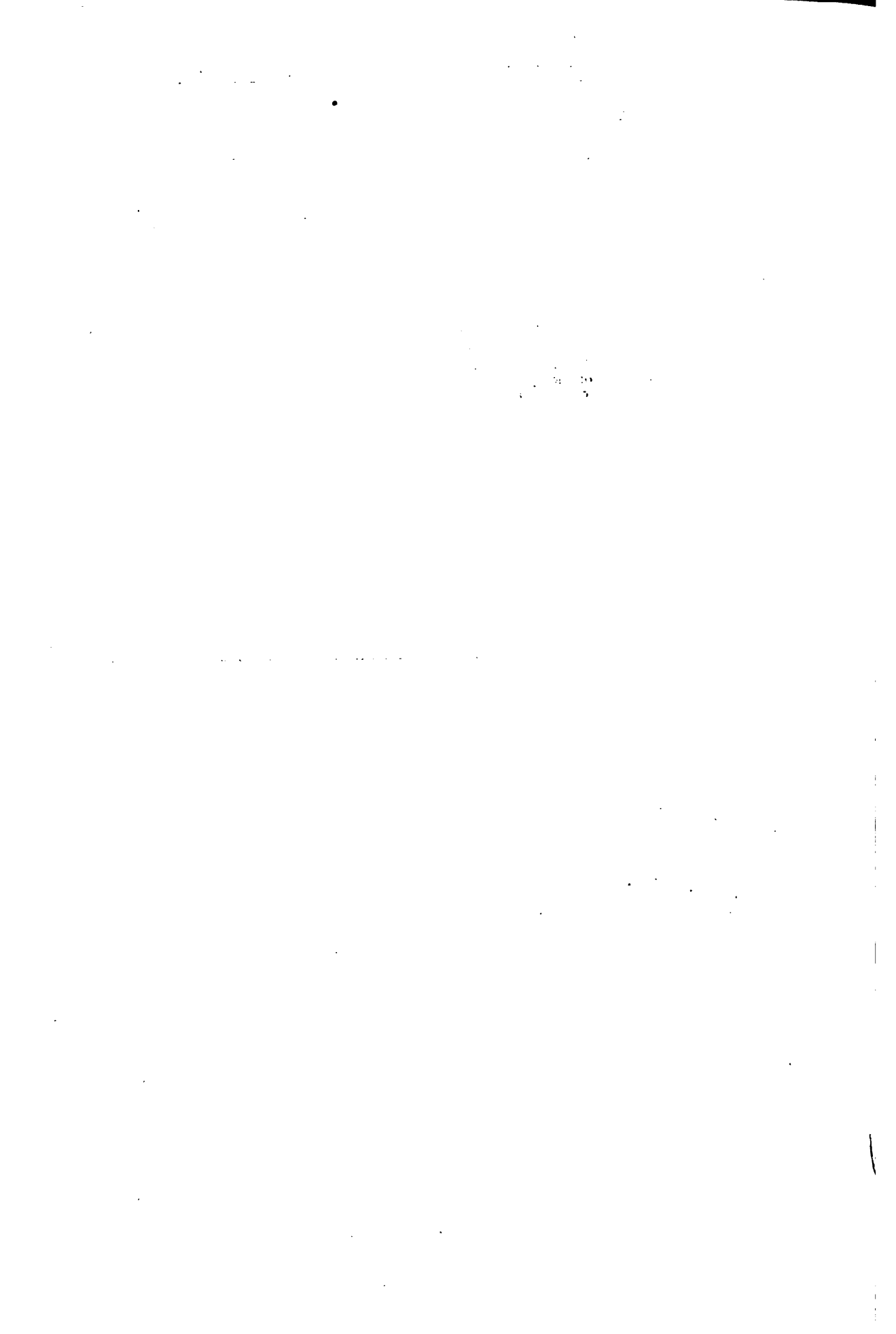


FIG. VI.—Tractor introduced; blades separated; traction made, exposing posterior surface of prostate. Incisions in capsule on each side of ejaculatory ducts (Young).



(b) Young: *Monatsberichte für Urologie*, Bd. IX, Heft 5, b. 6, 1904.

(c) Proust: "Technique de l'Incision prérectale, appliquée à la Chirurgie genitale chez l'Homme," Paris Thesis, 1902. *Centralbl. Harn. u. Sex. Org.*, 1903. Keith: "Human Embryology and Morphology," 2nd Edition. London, 1904.

(d) Petit: "De la Prostatectomie périaeal," Paris, 1902.

MEDICO-LEGAL RELATIONS OF INTEMPERANCE. (a)

By STANLEY B. ATKINSON, M.A., M.B., B.Sc.,
Barrister-at-Law, of the Inner Temple.

FORENSIC medicine is the science and art of medical evidence. Most cases involving intemperance which come before the law courts are unreported, for they turn on some question of fact which, once having been adjudged by the jury, is not likely to form a precedent. There are, however, many points of law which a judge has to consider when dealing with persons "under the influence of drink." How far is that condition an excuse? How far an aggravation of the alleged offence? What is an habitual drunkard? What is a drunkard's position with regard to matrimonial cruelty in law? How far do the Lunacy laws operate upon inebriates? *In sum*, under what circumstances may a man, or his compromised personal representatives, have to appear in Court after an alleged bout of alcoholic or other intoxication? Forensically, there are three classes of intemperate citizens:—1. The police-court inebriate, who is usually set at liberty after a fine has been paid; occasionally he may be dealt with as an habitual drunkard. 2. The man who wishes to be relieved by the Court from the legal consequences of some untoward conduct during a fit of drunkenness, which led to a criminally or civilly obnoxious result. There are many examples of this plea; in all, the law presumes that a man is sober, and he who affirms the contrary must prove his allegation. 3. Whenever excessive drinking has been the medical cause of death, the coroner should be informed of the fact of poisoning.

It is very difficult to define what actually constitutes drunkenness. A full clinical test should be applied to each case. The contemporary physical and mental health and the quality of the beverage will cause variations, a fact which helps to explain the different manifestations in men and in women. Moral and social environment also will explain apparent differences in the practical criteria: the prohibition villager has a different calculus from the city slum-dweller, where "the quickest way out of Manchester is to get drunk."

To three classes of practical men the definition and tests of drunkenness are especially important.

1. The publicans, who at their peril allow a drunken patron to be on their licensed premises. 2. The police, who are adepts in shifting responsibility by applying the cardinal canon of amateur "first aid"—they "send for the doctor." 3. The medical man, who, at times, after considerable delay, becomes the final referee. He subjects the police suspicions to scientific clinical tests. In wisdom he will give the patient the benefit of any doubt and tentatively treat him as if suffering from a serious disorder unless and until its fleeting nature is proved. The past history, recent or remote,

(a) Paper read before the Society for the Study of Inebriety, April 11th, 1906.

must not deceive him, either in dealing with the pre-comatose irritative stage or with the "dead drunk." There is no golden rule for testing drunkenness, and the patient may be a poor clinical witness. There are a few "rules of thumb," which may be reduced to scientific and clinical precision: abnormality in mental and in stational conditions are the most easily tested.

It appears from the wording of the Habitual Drunkards Acts that they refer only to the victims of alcoholic intoxication. Further, the Lunacy Acts do not embrace the inebriate as such; a man suffering from *delirium tremens* is without their scope. These facts are of great significance when it is remembered how many delirious and other mental conditions can be attributed directly to definite toxic substances in the circulating blood, that is, these conditions are to that extent concomitant incidents of physical disease; the whole question of the physiology and pathology of responsibility might be pertinently discussed under this heading.

To the lawyer the consequences of intemperance have been long established. The drunkard is legally responsible for his moral irresponsibility. A few exceptions, however, are tolerated. Actual contemporary drunkenness, if proved, may excuse the unconscionable effects of a contract, or reduce a will, for in such instances the respective *consensus* and *animus testandi* were obviously absent. In criminal law no excuse is allowed unless *delirium tremens* is proved to have affected the passionate offender; but here also a few exceptions are tolerated, e.g., where a man was unwittingly drugged (*quære*, by "doctored brandy"), or where the indictment affirms that a deliberate intention was present, or that consent was absent, the proof of actual intoxication may be pleaded successfully.

The mental facility consequent upon prolonged inebriety is not an effectual plea, nor would the assertion that one was visited with the iniquities of one's great-grandfather. There is often a recommendation to mercy in the verdict, and usually this implies that the jury considers the culprit "weak-minded"; drunkenness showed the criminal, it did not make him. It is regrettable that R. L. S. did not leave us the recipe for re-converting Mr. Hyde into Dr. Jekyll and keeping him so; to the inebriate it might have proved a philanthropic bequest.

THE CHEMISTRY OF CANCER. (a)

By DR. BLUMENTHAL,
Director of the Cancer Research Institute, Berlin.

[Translated by J. BEARD,
Lecturer on Embryology in University of Edinburgh.]

IN the course of the discussion (March 15th) upon cancer before the Berlin Medical Society, Dr. Blumenthal, of the Berlin Cancer Research Institute, made the following interesting and important remarks upon recent researches by himself and colleagues into the physiological chemistry of carcinoma. As reported in the *Berliner klin. Woch.* (March 27th, p. 376), he said: "The previous speaker (Dr. L. Pick) placed the question of the malignancy of cancer in the foreground of the discussion, and endeavoured to base this

(a) Speech delivered before the Berlin Medical Society at the recent Discussion upon Cancer. For Dr. Beard's remarks see page 380.

upon morphological and histological facts. Now, I believe that chemical facts are capable of explaining the malignancy of carcinomata much more than these, if we can show that the cancer-cell has a different composition than the epithelial cell, its mother-cell. If, further, we can prove that other chemico-biological characters are possessed by cancer-cells than by the ordinary epithelial cell, that would give us an explanation of the malignancy of the cancer-cell, for which hitherto every certain explanation was wanting. In the Institute for Cancer Research we have made investigations upon: (1) How are the cancer-cells built up? (2) Have they new biological characters? It has turned out that in fact the cancer-cell shows a chemical composition different from that of the somatic cell. It contains far more albumen and less globulin than all the remaining tissues. This is shown not only in the tumours, but also in the ascitic fluids of the cancer-patients. Here, also, an increase of the albumen is constantly present. Moreover, on three occasions a very interesting albuminous body could be isolated, the characters of which I will not now more closely describe. Then it was proved in melanoma that this substance has a quite different composition from the melanin previously formed in the organism. The 'skatol' group was wanting, hydrocyanic acid was easily derived, and so on. These facts indeed show that the cancer-cell is chemically not the ordinary epithelial cell, and that the latter has undergone a chemical transformation in becoming a cancer-cell. This will appear more evident from the following biological characters of cancer tissue. All carcinomata are always very easily digested by pancreatin, as Bergell demonstrated in our institute, while, on the contrary, all other tissues of the organism are fairly resistant to its action. This pancreatic digestion of cancer-tissue also takes another course than in other tissues. The terminal products are not reached, for the pancreatic digestion of cancerous tumours ceases at the intermediate products. But not only towards the demolition (Abbau) of the organism does the cancer-cell manifest another relation than the other organic cells, but also in the building-up there are considerable differences. Thus, Salakowski showed that in all the tissues of the organism autolytic ferment occurs, which has the property of splitting up the albumen of the same organ. Thus, for example, liver-ferment splits up liver-albumen, and lung-ferment lung-albumen, but only lung-albumen. A similar ferment also occurs, as Petry has shown, in the cancerous tumour. But, as Wolff and I found, the cancer-ferment exhibits also quite other properties. It not only possesses the power of destroying the cancer-albumen, but it pulls down with perfect ease (spielend leicht) the albumen of other organs. In the Pathological Institute here C. Neuberg has obtained similar results. Neuberg showed that liver-cancer was able to split up in the most intense fashion lung-albumen. It follows from these investigations that the epithelial cell must first of all have transformed itself in becoming a cancer-cell. This is, as I believe, of import for the question of malignancy, that is, for the question of the cancer-cachexia. We know that there are cancers which are exclusive and firm, and which for a long time cause no appearances

of cachexia, while, on the other hand, other cancers exhibit it (cachexia) comparatively early without any considerable formation of metastases. With the aid of this cancer-ferment this can be explained. In the cells which do not break up, which are tough, there is no splitting up of the cancer-albumen. In consequence of this no ferment is freed, and no ferment can get into the circulation. But in those cancers which easily disintegrate, much ferment is freed, gets into the circulation, and can now in other organs effect a considerable destruction of the somatic albumen, that is to say, produce cachexia. I believe that these facts, which are not entirely unimportant, explain to us at least the cancer-cachexia, even in those cases in which hitherto it has been inexplicable. In conclusion, I should like to mention that these results would not have been possible to us in so short a time had we not been supported by the State and by the Committee for Cancer Research in a fashion deserving of the utmost thanks, and thus we were enabled, not only to win over competent workers, but also to obtain very expensive apparatus, with which these investigations could be carried out."

THE DIFFICULTIES AND DANGERS OF THE RADICAL MASTOID OPERATION.

By HUGH E. JONES, M.R.C.S.,
Hon. Surgeon, Liverpool Eye and Ear Infirmary.

AFTER defining the operation and referring to the work of Schwarze, Stache, Kuster, and Balance, he enumerated the *difficulties* peculiar to this operation: The selection of suitable cases, which consisted in (1) limiting the complete operation to cases which really required it; (2) deciding whether to operate or not on cases where there is grave general disease; (3) avoidable difficulties on the part of the operator, such as working in a poor light or without an intimate knowledge of the anatomy of the part; (4) unavoidable difficulties, e.g., variations in the position and size of the antrum, sclerosis of the bone, and a forward position of the lateral sinus.

The facial nerve was the most important structure to avoid, and there were several ways in which it might be injured: (1) By the faulty introduction or careless holding of Stacke's protector; (2) by the too free removal of the posterior wall of the meatus at its inner end; (3) the bone, if brittle, might be cracked by the chisel at a point not intended; (4) by careless curetting in the region of the fossa ovalis and sinus tympani; (5) by curetting cells or fistulae, in the lower deep anterior part of the petromastoid or posterior wall of the meatus. The difficulties of skin-grafting, provided the whole of the disease had been eradicated, were purely technical, and could be overcome by practice and patience. Packing was advocated in cases in which it was not certain that the whole of the diseased tissue had been removed. The *dangers* peculiar to the operation were classified as follows: (1) Those arising from coincident general disease, e.g., advanced tuberculosis, diabetes,

(a) Abstract of Paper read before the Liverpool Medical Institution, March 30th, 1905.

marasmus and congenital syphilis, in infants; (2) coincident undetected intracranial disease, e.g., serous meningitis, latent cerebral abscess, acute cerebral abscess; (3) pathological conditions within the temporal bone might be stirred up and cause an extension of the septic process, which might result in suppurative meningitis or sinus phlebitis; (4) leaving foci of infection by incomplete operation. This was perhaps the greatest danger of all.

It was the duty of the operator, whether a general surgeon or an otologist, not only to be prepared to face and learn to master any of the difficulties and dangers enumerated, but also to see his patient safely through to a complete and final healing of the wound.

Transactions of Societies.

ROYAL ACADEMY OF MEDICINE IN IRELAND.
SECTION OF SURGERY.
MEETING HELD FRIDAY, MARCH 24TH, 1905.

The President, ARTHUR CHANCE, P.R.C.S.I., in the Chair.

EXHIBITS.

THE PRESIDENT exhibited a patient who presented an unusual condition of the hip subsequent to injury.

Mr. KENNEDY exhibited—(a) patient operated on for internal strangulation by a band; (b) case after amputation through the shoulder-joint; (c) two cases of talipes equino-varus.

PAINLESS HÆMATURIA.

Mr. L. G. GUNN read a paper on painless hæmaturia, showing the difficulty in making an accurate diagnosis in these cases, many of which may prove eventually to be of a very serious nature, and gave a short account of five cases of painless hæmaturia which had passed through his hands during the last few months; all had the common symptom of blood occurring in the urine, but in each case the cause of the hæmorrhage differed, and could not in all probability have been discovered without the use of the investigation and ureteral catheterisation cystoscopes, both of which were demonstrated. The great importance of finding out accurately the functional capacity of both kidneys in cases where it might be advisable to remove one kidney was also discussed, and the method of doing this by means of Prof. Luy's segregator, and the cystoscopic examination of the separate urine were fully explained, and examples given of the value and accuracy of the method, both as regards prognosis and treatment. The cause of the hæmaturia in the first case was believed to be due to an angiomatous condition of the renal papillæ of the left kidney, all the other likely causes of bleeding being excluded one by one, but as the patient refused any operation, the diagnosis was not confirmed as it was in the remaining four cases. The hæmaturia in these cases proved to be from, in No. 2, a severe degree of interstitial change in the left kidney, the right being healthy, and secreting, after the removal of the diseased left, from 40 to 50 ozs. of healthy urine during the day; in Case 3, a chronic tuberculous ulceration of the bladder was the cause; the floors of several of these ulcers bled when the bladder was gently distended through an irrigation cystoscope; in Case 4 the cause was an adenoma of the left kidney, which was removed by operation; while the last case was one of carcinoma of the prostate invading the bladder wall, part of which was successfully removed with the diseased prostate.

Mr. EDWARD H. TAYLOR, in congratulating Mr. Gunn on his communication, said that it confirmed his belief in the great value of cystoscopic examination in urinary cases. In the case recently under his care, Mr. Taylor had derived very valuable information concerning obscure bladder symptoms with Mr. Gunn's assistance. Cystoscopy and ureteral catheterisation appeared to

be methods of investigation requiring such a high degree of technical skill as to belong to the specialist rather than to the general surgeon.

Mr. T. E. GORDON agreed with what had been said by Mr. Taylor. He thought that the methods of examination described by Mr. Gunn were essential in a large proportion of cases, and would in future devolve on specialists.

Mr. G. JAMESON JOHNSTON congratulated Mr. Gunn on his contribution to the recent advances in renal surgery, and the manner in which he had worked out his cases.

PURULENT COLLECTIONS.

Mr. ROBERT WOODS read a paper in which he discussed the laws governing the formation of purulent collections, and the way in which those laws affected surgical treatment. In the first place he dealt with soft tissue abscesses; secondly, with those in which one wall of the cavity was fixed; and thirdly, with purulent collections inside fixed walls. From theoretical considerations, he arrived at the conclusion that the correct way in which to treat empyema of the pleura was not by dependent drainage and subsequent resection of the chest wall when necessary, but by applying negative pressure to the pleural cavity, and obviating the tendency of the lung to retract. In discussing multiple sinusitis, he mentioned that after performing the radical operation on the antrum of Highmore, according to the Caldwell-Luc method, he had on three occasions grafted the inside of the antrum by Thiersch grafts with good results.

Mr. G. JAMESON JOHNSTON disagreed with Mr. Woods regarding the treatment of abscess in the tibia, but he hoped the apparatus devised by Mr. Woods for the treatment of empyema would prove workable, as he considered Estlander's operation a disgrace to medicine. He wished to hear from Mr. Woods if his apparatus could cause expansion of the lung if the pleura had increased considerably in thickness.

Mr. E. H. BENNETT, in discussing Mr. Woods' communication, expressed himself opposed to the treatment recommended for empyema. He thought that attempts to exclude air from the pleural cavity by means of plugs would fail, as these could not be borne with comfort.

Mr. EDWARD H. TAYLOR considered Mr. Woods' apparatus most ingenious in its construction. He thought that if it were to succeed it would be in empyemata of recent formation, in which extensive pathological changes in the pleura had not yet taken place.

Dr. TRAVERS-SMITH considered the surgical treatment of empyema most unsatisfactory. He regarded Mr. Woods' idea as a most ingenious one, and he was prepared to give his apparatus a trial in the next favourable case which came under his care.

Mr. BLAYNEY thought Mr. Woods' apparatus was not necessary in recent cases, as the lung usually expanded after the evacuation of the pus. For old standing cases he agreed, with others who had spoken, that the apparatus would be useless, but he thought there was a fair field for it in certain cases which came between these—viz., in which the thickening of the pleura was but slight.

Mr. PATRICK DEMPSEY and Mr. R. A. STONEY also discussed the communication.

Mr. WOODS, in reply, stated that his apparatus was designed, not for localised empyemata, but for the more extensive kind in which the general pleural cavity was involved. He did not consider it would be of any use in those cases in which the pleura was much thickened.

LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD MARCH 30TH, 1905.

Dr. JAMES BARR, the President, in the Chair.

Dr. JOHN HAY read a note on Bradycardia, in which special reference was made to that form of pulsus varus caused by "heart block." He described in

detail the case of a man, *æ*t. 26, in whom the rhythm of the auricles was independent of, and different from, that of the ventricles. The following were the important features of the case. 1. Marked infrequency of the pulse, which varied from 17 to 30 beats per minute. 2. Transient loss of consciousness associated with disappearance of the pulse at the wrist. 3. Auricular contractions occurring much more frequently than, and independently of, ventricular contractions. 4. An enormous heart, weighing 29 ozs. The autopsy revealed no cause for this increased size. The heart was exhibited and also a drawing of it made by Professor A. Keith, of London, who was of opinion that there was a stretching of the auricular canal and also an attenuation of the band between the base of the tricuspid valves and the base of the ventricle. The second case was that of a man, *æ*t. 62, in whom the heart block was not complete. There was marked depression of conductivity, the time taken by the stimulus to pass from the auricle to the ventricle being double its normal length. As a result of this, only every other contraction of the auricles was able to excite the ventricles to respond. The pulse-rate was 32 per minute, and although the patient was apparently in good health, he had a very much diminished area of cardiac response. The note was illustrated by charts, diagrams, pulse tracings, and lantern slides.

Dr. W. B. Warrington, Dr. C. J. Macalister, Dr. R. J. M. Buchanan, and Dr. W. Carter took part in the discussion.

Mr. ROBERT BICKERSTETH read a note on Prostatectomy, and after quoting case-histories in illustration of his remarks, he discussed the circumstances which should guide the surgeon in his choice between the suprapubic and the perineal routes. He pointed out the necessity for a very full and careful examination of each individual case, and showed how it was generally possible in this way to distinguish in advance between those prostates which are easily removable and others in which removal may be a matter of very considerable difficulty. For the easier cases, which comprise the fibro-adenomatous enlargements, and form the bulk of the cases requiring operation, the suprapubic operation, and enucleation after Mr. Freyer's method, is certainly the operation of choice. There remain other cases, however, in which it seems likely that enucleation with the finger will be either very difficult or altogether impossible. For these the perineal operation is best, a transverse incision securing a full exposure and a good view of all the parts concerned. Lantern slides illustrating the successive stages of such a perineal operation were shown, and the general indication for prostatectomy were further discussed.

Remarks were made by Mr. A. C. Ballance and Mr. D. Douglas-Crawford.

Mr. HUGH E. JONES read a paper on the "Difficulties and Dangers of the Radical Mastoid Operation, which will be found on page 376.

Mr. CHAS. A. BALLANCE (London) also read a paper on the same subject.

Dr. W. MILLIGAN said that the fundamental principles of surgery should be adopted in the treatment of septic disease of the temporal bone—viz., free exposure of the diseased area and the establishment of free drainage. The peculiar anatomical difficulties of this region should be very carefully studied before undertaking the radical operation. He exhibited various sections of the temporal bone in order to demonstrate some of the difficulties described by Mr. Jones. The treatment of the soft parts was of the utmost importance, and he was an enthusiastic advocate of the grafting operation, which not only materially diminished the length of the after-treatment, but secured more certain results, especially in so far as the healing of the inner tympanic wall was concerned. Continuous and light packing was irksome to the patient and to the surgeon, and he was inclined to think that it tended to promote rather than to retard the growth of exuberant granulation tissue. In the treatment of tuberculous cases he advocated in the first instance merely providing efficient

retro-auricular drainage, together with the removal of sequestra, and later, when the general condition of the patient had improved, the performance of the radical operation.

Mr. W. Thelwall Thomas, Mr. E. M. Stockdale, Mr. Edgar Stevenson, Mr. J. Bark and Dr. W. B. Warrington also took part in the discussion.

NORTH-EAST LONDON CLINICAL SOCIETY.

CLINICAL MEETING HELD THURSDAY, APRIL 6TH, 1905.

Dr. R. MURRAY LESLIE, President, in the Chair.

THE following cases were exhibited:—

Dr. F. J. TRESILIAN (Enfield) showed a man, *æ*t. 74, the subject of motor aphasia with agraphia, unaccompanied by hemiplegia.

Mr. HERBERT CARSON showed a little girl, *æ*t. 6, with a small cyst in the right temporal region which he was of opinion, would prove to be of dermoid origin. He proposed to explore the swelling and report as to its condition at a future meeting of the Society.

Mr. HERBERT ALEXANDER exhibited a case of tumour of the manubrium sterni in a girl, *æ*t. 9. The swelling was ill-defined in outline, apparently connected with the bone, and it was not tender on percussion. It had existed for ten weeks, and previous to this she had been out of sorts, and had had some pyrexia. The treatment consisted in the administration of mercury, potassium iodide, and afterwards arsenic and cod-liver oil. There were no signs of congenital syphilis. A skiagram of the upper part of the thorax revealed a slight shadow in the position of the tumour.

The PRESIDENT remarked that he had seen three similar cases, two of which had proved to be tuberculous periostitis of the sternum. He was inclined to put the present case under this category.

Mr. CARSON considered that the diagnosis lay between tuberculous mischief and some form of new growth. He thought that gumma might be excluded, but the chances were that the trouble was situated within the manubrium itself—i.e., it was probably a tuberculous osteitis. He had operated upon one similar case, which proved to be a sarcoma.

The PRESIDENT showed (1) a case of paresis of the right arm and left leg in a girl, *æ*t. 9, probably of a functional character. There was considerable difficulty in walking, and the right grasp was feeble. The condition had lasted for three weeks. There was no muscular atrophy, and no history of any palatal trouble or previous sore throat; indeed, her general health was good. The case was, therefore, distinctly obscure.

(2) A case of complete transformation of the viscera in a young woman, *æ*t. 19. The condition was of the "mirror" type and was discovered quite accidentally.

(3) Two cases of aneurysm of the aortic arch in men, *æ*t. 57 and 43 respectively. The first case presented the phenomenon known as "tracheal tugging" in a very marked degree, and also pressure symptoms, the left vocal chord being paralysed. The second case showed no tracheal tugging, but considerable engorgement of the veins of the thoracic wall and inequality of the radial pulses.

Mr. CARSON read notes of a case of intestinal obstruction due to malignant disease of the sigmoid and showed the growth, which he had resected eight days after a preliminary colotomy. He emphasised the importance of the proctoscope as an aid to the diagnosis of diseases of the rectum and sigmoid flexure. When employed in the "knee-elbow" position, which was quite an easy procedure, the whole of this portion of the intestinal tract could be thoroughly explored, and in this manner morbid growths of the parts could be detected much earlier. He considered that removal of malignant neoplasms should be attempted in all cases where the growth was fairly movable, and where it was able to be brought out of the abdomen. Otherwise a short circuit might be made to relieve obstructive symptoms when these appeared.

Dr. ARTHUR GILES showed a specimen of a similar

case from a female patient upon whom he had operated in the Chelsea Hospital for Women. In this case excision of the growth was performed three weeks after the colotomy. He was much struck with the fact that frequently no symptoms were presented by malignant growths in this region until obstruction suddenly set in.

Dr. T. D. MANNING (Hoddesdon) referred to a case recently under his care of a man in whom hæmatemesis had occurred from a gastric ulcer, and who afterwards suffered from extreme anæmia, which was attributed to the same cause. One day, however, the rectum was examined and found to be completely blocked by a malignant growth.

Dr. GILES also showed: (1) a fœtus at full term from a case of extra-uterine foetation upon which he had operated. At the time of examination, five weeks previously, the cervix was felt to be high up behind the pubes, but the child was alive. In view of the increased risk to the mother of operating when the placental circulation is still in full activity, and the small chance of rearing the child of an extra-uterine foetation, it was decided to wait five weeks. When the operation was performed the placental site was seen to be in connection with the left tube and broad ligament. There was no trace of any rupture of the tube itself. (2) A tubal mole which he had likewise removed; and (3) specimens of uterine fibroids illustrating (a) the association of fibroids with pregnancy; (b) the so-called "red fibroid," in which muscular tissue preponderated; and (c) a cervical fibroid from a patient in whom pan-hysterectomy had been performed. The tumour in this case had formed a complete cast of the pelvis.

THE SOCIETY FOR THE STUDY OF INEBRIETY.

At the Quarterly Meeting of the above Society, held on TUESDAY, APRIL 11TH, HARRY CAMPBELL M.D., F.R.C.P., President, in the Chair, at the rooms of the Medical Society of London, STANLEY B. ATKINSON, M.A., M.B., B.Sc., Barrister-at-Law, of the Inner Temple, opened a discussion on

MEDICO-LEGAL RELATIONS OF INTEMPERANCE.

France.

[FROM OUR OWN CORRESPONDENT.]
PARIS, April 9th, 1905.

TREATMENT OF BOILS AND ANTHRAX.

M. PAUL RECLUS recommends the following treatment of boils and anthrax:—Pulverisation or spraying of the parts with a weak sublimate solution (1-1000) or phenic acid (1-100) or oxygen water and, more frequently, simple boiled water. The spray should last half an hour, after which the region is dried and an antiseptic ointment applied. Under this treatment the pain subsides, but returns in five or six hours, when the pulverisation should be repeated; this should be done four or five times in the twenty-four hours. Under its influence the inflammatory zone becomes retracted, the boil bursts and the cure is rapid. As to the bistoury, he did not recommend its frequent use, and only when the pain is intense, the tumour continuing to extend, and when the boil is situated in a dangerous region, such as the face or upper lip, on account of meningo-cerebral complications. Nothing is more variable than the pain of boils and anthrax: some provoke intense suffering, while others are almost painless.

Verneuil considered that painless boils were generally found in diabetic patients. In any case, in painful boils or anthrax the bistoury should be employed when, after two or three séances of spraying and the application of an antiseptic ointment, no improvement takes place; a local anæsthetic may be used for boils, but in anthrax the patient should be put under chloroform. For boils the best agent is stovaine (1-100). The needle of the syringe is pushed under the healthy skin at a certain distance from the inflamed boil, and the injection made slowly in every sense beneath the tumour, which becomes white under its influence. It is then opened freely without the slightest suffering and the parts washed with oxygen water.

In cases of anthrax, the thermo-cautery should take the place of the bistoury. The incisions should be made from the centre to the circumference like the spokes of a wheel. Yet when possible, abstention from operating is better, for the loss of substance caused by the cautery is considerable, and the patient takes months to get well. The cure is much more rapid in anthrax that has not been operated on.

When the boil is on the upper lip, the thermo-cautery should be applied if the spray and the antiseptic ointment produce no effect, and especially if the infection show signs of spreading towards the region of the facial vein.

The general treatment should not be neglected, especially when the affection was traced to a diathesis as diabetes, albuminuria.

Intestinal disinfectants, such as benzo-naphthol, beer yeast, &c., and large effusions of the body followed by friction with an alcoholic liniment or spirits of camphor.

ARTHRITIC PHARYNGITIS.

In the treatment of arthritic pharyngitis the acute and chronic stages must be taken into account. In the former M. Heckel advises rest in bed, sudation, hot drinks. The local treatment consists in the employment of an antiseptic ointment passed into both nostrils morning and evening:

- Menthol, 6 grains;
- Boric acid, 15 grains;
- Vaseline, 1 oz.

Inhalations of

- Peruvian balsam } æq. partes.
- Proof spirit }

A few drops in half a glass of boiling water to be inhaled five minutes, three or four times a day.

In the chronic form sulphurous or arsenical waters should be used both internally and externally in the form of spray. Of these mineral waters the best are Saint Honoré or Challes (sulphurous), Mont-Deve, Bourboule (arsenical). In certain cases it is well to alternate, three weeks sulphur, three weeks arsenic. In the atrophic forms, M. Heckel recommends the application of

- Iodine, 15 grains;
- Iodide of potassium, 1 drachm;
- Water, 1½ ozs.

The pills of Morell Mackenzie are also of service.

- Chlorate of potash, 3 drachms;
- Extract of eucalyptus, 1 drachm;
- Cubebs powder, ½ drachm.

For one pill. Two or three before speaking or singing.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BREITEN, April 9th, 1905.

DISCUSSION ON THE ETIOLOGY OF CANCER (Concluded)

HR. BENDA professed himself an adherent of the parasitic theory—no other was so capable of explaining facts. Cohnheim's theory of embryonic germ origin did not answer for malignant tumours. Whoever used this theory in explanation would have to assume that these embryonic cells retained their embryonic character through life, whilst in reality they did not do so; and, secondly, that embryonic cells were capable of unlimited growth, whilst at the same time retaining their inherited tendency of development. The transferences were transplantations, not infections. What had been up to now demonstrated in the cell inclusion were not the parasites sought for, for they were not found in all, but only in a few carcinomata. In spite of all these objections, however, as the irritation that converted epithelial cells into cancer cells must be sought in the cell itself, changes in the cell organs could not be explained. Still, he held that the irritation could be best explained by a parasite, so long as no better explanation could be offered. The parasitic theory gave the best hopes of discovering some method of fighting the disease.

Hr. Pick thought the difficulty of the cancer problem lay in our not understanding the causes and

nature of physiological cell life. Up to now we had our attention drawn to the morphology of cancer cells, and this only permitted probabilities as to the nature of their inner processes to be drawn. The epithelium malignum of the chorion showed that there was no need to assume a parasite in order to understand malignant proliferation. This was very malignant, but it offered an opposition to physiological chorion. Even in normal chorion destruction of mucous membrane and even of muscular tissue had been observed among the physiological processes of pregnancy. From these physiological processes a complete series could be made out even up to the most malignant epithelioma of the chorion. Here one was compelled to assume either that the original deposition of ovum was parasitic, or that a parasite was not an essential part of the process. The assumption of a parasite was not necessary for other carcinomata.

Hr. H. Blumenthal said that the malignancy of cancer cells showed itself most in their chemical properties, as had been determined in the Cancer Institute. Cancer cells had far more albumen and less globulin than normal epithelium. The same was true of the ascites of cancer. Three times, also, an albuminous body had been met with in cancer that was not otherwise known. The melanin also of sarcoma was differently constituted from ordinary pigment—all this showed that the cancer cell was not a simple epithelial cell. For this reason the cancer cell was digested with difficulty by pepsine, but readily by pancreatin, although this did not come until the end of digestion. Salkowski had shown the universal presence of an autolytic ferment; the cancer cell also had a ferment that acted destructively on all other body cells. From all this was to be concluded that the epithelial cell, before it could become a cancer cell, must have undergone a chemical change. The cancer ferment explained the malignancy and the especially pronounced cachexia.

Hr. O. Israel disputed the possibility of a parasitic origin.

In Virchow's "Zellstaate," the cell divided and subdivided in unbroken series until by the laws of phylogenesis and autogenesis the desired aim was reached. But cell division did not then cease; in various parts it continued actively; thus in the skin mitosis went on during the whole of life as the expression of cell division. The new growth on the skin had its cause in the continued casting off of epithelial cells and the attempts at regeneration called for by the process. Regeneration, however, did not go on everywhere to the replacement only of lost parts, but often beyond this. This excessive power of increase of the cells was gradually heightened by heredity, and finally let loose by the death of neighbouring cells. In places exposed to chronic inflammation persistent loss led to increased regenerative growth, which in the descendants of these cells led to an excessive growth of cancer cells.

If a parasite found its way into these cells, the cell or the parasite died; that, however, division and continued development of cells took place we had no example.

Hr. Olshausen, without being an adherent of the parasite theory, would point out the following facts:—(1) The local enormous spread of cancer, which could not be purely accidental; (2) the enormous increase of cancer in recent years, in some cases an increase of 100 to 200 per cent., and which could not be explained by improved diagnosis; (3) the occasional transference of cancer from one part of the body to another lying opposite to it, where a stereotype impression of the original cancer developed. New methods of inquiry were necessary.

Hr. Behla would explain the local increase of cancer by an aquatic parasite that was disseminated by raw vegetables.

Hr. Orth laid stress on experimental transplantation and maintained that Olshausen's stereotype reproduction was nothing else.

Hr. v. Leyden did not feel his ground weakened. The chemical factor was interesting; it proved nothing

as to parasites, but showed simple cell changes. As regarded cancer ferments, Neuberg had shown that metastases differed widely from the parent tumour. This could be explained by changes in the cell character, but not by parasites.

Hr. Henke was of opinion that it would be a very important matter to discover a mark of distinction between a typical epithelial growth, for example, on a lupus scar, and from carcinoma. He had busied himself in the subject, but in vain; at present nothing remained but Orth's quantitative heteropty.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, April 8th, 1905.

CALLOUS GASTRIC ULCERS.

At the Gesellschaft der Aerzte Bakes gave the members an exhaustive review of gastric ulcers and their treatment, but the hard, chronic, open sore of the stomach was the morbid condition that he wished his hearers to examine more particularly. Hitherto the treatment could not be considered anything more than palliative at the best. Gastro-enterostomy has been practised with varying degrees of success, but subsequent hæmorrhage or perforation has too often undone the anticipated good results. Gastrectomy promises to be a more satisfactory operation which is no more dangerous or risky in performance than gastro-enterostomy.

He had now resected seventy-five of these callous ulcers by different methods according to the recommendation of the authors. He considers a combination of general and local narcosis to be the best in laparotomy. He first opens the abdomen under Schleich's local anæsthesia, following it up with ether inhalation. He commences his incision at the processus xyphoideus, extending it to the inscriptio tendineæ of the rectus, making a curve half-way through the muscle outwards. There are conditions where resection may be performed by Eiselsberg's operation for removal of the pylorus. During the last year he had performed seven such operations with perfect success, three of which histologically proved to be carcinomatous. He recorded another similar case where he had operated which died within twenty-five hours after the operation from pancreatic necrosis.

In the discussion Lorenz reminded the members that Hinterstoisser advocated this very treatment a year ago. Resection was undoubtedly the ideal treatment in all such cases, but there were many of these cases fraught with great danger to life. The callous ulcer and the callous penetrating ulcer were two very different morbid processes. The penetrating gastric ulcer seemed to be identical with Hofmeister's disease, which he described as a destructive tumour of the stomach, extending far beyond its walls, invading the neighbouring organs such as the spleen, liver, and pancreas. In these seemingly fatal cases he was inclined to favour Hochenegg's method, which he had seen carried out successfully in two such cases. He placed tampons between the ulcerated portions of the stomach and liver or other affected organs, and then performed posterior gastro-enterostomy. In both a drainage-tube was left in the stomach, through which they were fed as in gastrostomy. Both recovered and are now well two years after the operation was performed. It would be unfair to deduce any principle from these operations, as no fixed law can be laid down for these complications. Clairmont thought that Eiselsberg's treatment was more palliative than radical, which simply explained his gastro-enterostomy or jejunostomy. The penetrating callous ulcer is not as a rule hard to diagnose, but to recognise the situation of the ulcer is a more critical point. There are cases of ulceration for which resection is not suitable, as, for example, one recorded by Neusser where the operation revealed changes on the outer surface of the organ, while the ulcer was located in the smaller curvature near the cardiac end, which was far removed from the other changes. He performed jejunostomy according to Witzel and Eiselsberg's method, but the patient

died from severe hæmatemesis within twenty-four hours. The *post-mortem* revealed a large perforating ulcer extending along the cardiac end of the stomach.

INFANTILE PSEUDO-BULBAR PARALYSIS.

Schüller demonstrated three cases of cerebral diplegia to the members of the Society for Internal Medicine. All the three children were relatively well developed in both body and mind, and no apparent disturbance in any of the senses. The movements of the upper and lower extremities were distinctly interrupted by contractions, co-ordinate movements, ataxia, and athetosis. He wished to add another symptom which he has not hitherto seen described in any of the published cases—viz., convergence of the pupils in children, which he considered of great pathological value. The treatment he proposed was the exercise therapy.

INDURATED ERYTHEMA.

Escherich showed a child, æt. 9 months, suffering from Bazin's disease. The child was well developed, no hereditary taint, fed at the breast, skin normal colour, without any symptom of rachitis or the lymphatic diathesis. About the third month, spina ventosa appeared on the middle finger of the right hand. On the left leg a number of small nodules occurred, varying in size from a hazel nut to a walnut, lying in the skin, and having a livid appearance and hard to the touch, without any apparent, surrounding changes. Only one of these nodules had a scurfy character. All of them commenced from a small centre and in a few weeks reached a walnut size, after which they began to diminish and disappear. He concluded with a differential diagnosis.

Hungary.

[FROM OUR OWN CORRESPONDENT.]

BUDAPEST, April 6th, 1905.

At the recent meeting of the Royal Society of Physicians of Budapest Dr. Navratil exhibited an uncommon case of

BARLOW'S DISEASE

which had not previously been observed in Hungary (with the exception of one case described by Dr. Gross Gyula).

The child, æt. 15 months, was fed from birth to the age of 12 months simply on boiled milk, and later on she was given a mixed diet (soup, eggs, and meat). On this *regime* the child, it is stated, developed very well. Her first tooth came in her tenth month, and she began to walk in her twelfth month. About six weeks previously her limbs began to be the seat of pain, and to become swollen. On the two following days she had bleeding from her mouth and bloody stools. At the end of January her head suddenly became swollen, as did also the eyelids. It was in this condition that she was brought to the surgical section of the hospital, where the case was kept under observation until February 12th. The diagnosis was hæmatoma capitis. The swelling diminished visibly after the application of wet compresses, so that at the time of her discharge from the hospital no tumour could be felt. On February 25th, the child was again brought to hospital. She looked delicate, and was very under-developed, and showed the characteristic signs of rachitis. The shafts of the left thigh bone and the left tibia were enlarged, and on palpation hard, irregular swellings could be felt. Both parietal regions of the skull were covered with a swelling, through which, on deep pressure, one could feel the sparsely-covered bone. Both upper and lower eyelids, as a whole, were of a bluish-red colour. From these symptoms the diagnosis was established—viz., Barlow's disease. Especially characteristic were the following symptoms:—Rapid development, pains in limbs, subperiosteal hæmorrhages over the long bones and the skull bones, in addition to hæmorrhages from the mouth and bowel. Barlow's disease would appear to be an affection *sui generis*, the etiology of which is still obscure.

Dr. Alapi Henrik exhibited a case of an affection of the accessory sinus of the nose associated with

PARALYSIS OF OCULAR MUSCLES.

He pointed out that chronic diseases of the sphenoidal sinus are usually accompanied by severe symptoms, and on account of its close neighbourhood to the eye it might entail various diseases of that organ. In the patient shown a year ago diplopia developed. Diseases of the antrum of Highmore and of the frontal and ethmoidal sinuses having been excluded, the headache and other severe symptoms led him to seek for the seat of the disease in the sphenoidal sinus, and he therefore made an opening into the sinus through its anterior lower wall.

The ptosis and the protrusion disappeared on the following day, and the patient could move his eye better. Two days later, after the removal of the anterior part of the middle turbinal, he scraped out the granulations lodged in the sphenoidal sinus. The patient felt very faint under this treatment, otherwise he professed himself quite well. The eye now moves inwards to the middle line, upwards only a little, downwards tolerably well. The posterior wall of the eye was intact. The patient denied having had syphilis, nor had he previously had any infectious disease. This made it very difficult to assign the real cause of the affection. That the eye muscle paralysis is dependent upon the sphenoidal disease appears likely, and this view is confirmed by anatomical considerations; it is confirmed, moreover, by the result obtained.

Operating Theatres.

WEST LONDON HOSPITAL.

CHOLECYSTECTOMY.—MR. SWINFORD EDWARDS operated on a woman, æt. 62, who had been admitted to the hospital with constant pain in the right hypochondriac region. She was slightly jaundiced: the motions, however, were of the proper colour; there was no history of her having passed any gall-stones. The pain had been present off and on for the past six weeks, but was now getting worse. She had had uneasiness in this region on two or three previous occasions. On examination under an anæsthetic, a hard mass was to be felt under the ninth costal cartilage, occupying the position of the gall-bladder; a diagnosis of gall-stones was therefore made, and an operation for the relief of this condition agreed to. An incision was made in the usual site, that is to say, vertically downwards from the ninth costal cartilage through the sheath of the rectus, the fibres of which were separated and then the posterior layer of the sheath and the peritoneum divided. Before the operation commenced a good sized sandbag was placed across the back in order to throw up the under surface of the liver and thus enable the surgeon to reach the parts more easily. On lifting up the anterior border of the liver the gall-bladder was seen and found to be somewhat distended with a hard mass. The gall-bladder was now incised with a view of enucleating its contents; these contents proved not to be calculi in the ordinary acceptation of the term, but a hard mass the outside of which was almost incorporated with the gall-bladder itself, whilst the interior of the mass could be scraped out with a Volkmann's spoon as the consistency was somewhat less dense. As the gall-bladder could not be cleared of its contents, Mr. Edwards decided to remove it; this was done with but little difficulty. During the dissection to free the gall-bladder from the under surface of the liver, two or three bleeding points had to be secured. A ligature was passed round the cystic duct, which was firmly tied and the cyst removed. A rubber drainage-tube was passed down to the position lately occupied by the gall-bladder and the rest of the

wound closed. Mr. Edwards said that before removing the gall-bladder it would be noticed that he made a careful examination of the common duct throughout its whole length, but found no concretion in any part of it. On examining the specimen it was found that apparently there had been some osseous or calcareous deposit in the walls of the gall-bladder, which were so hard that they could not be cut with a knife. He had not, he said, come across this condition before and conceived there was no other course open to him but to remove the tumour *en masse*.

It may be mentioned that the patient made a good recovery and left the hospital within three weeks with the wound soundly healed, the pain having disappeared, whilst the jaundice had become barely perceptible.

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The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, APRIL 12, 1905.

MEDICINE AND POLITICS.

THE relations between the medical profession and various governments is a matter of much interest. From the nature of their pursuits, medical men are closely connected with the administration no less than the progress of State medicine. As we all know, the field of medico-political interests is continually widening, as, for instance, in such points as modern substitutes for quarantine, the destruction of ship-rats and re-vaccination Bills. So far as the private interests of the medical profession are concerned here in the United Kingdom, there is grave reason to complain of the absence of internal self-government and of the scant amount of protection afforded to legitimate practitioners of medicine. Medical men in our own country, however, are free to come and go and to hold meetings, and to say what they like about any subject under the sun, whether it have any bearing upon their profession or not. In Russia, on the other hand, the absolute autocracy represented by the Czar controls the doings of medical men in their homes, their consulting rooms, their universities, their journals, and last, but not least, their scientific societies and meetings. But the unexpected has

happened, even in long-suffering Russia. In our issue of last week we pointed out that it was doubtful if the police would permit the holding of the Moscow Medical Congress. While the journal was still in the press news came that the Congress was to be held. The outcome of the meeting shows that the action of the police was not without some warrant, that is to say, from their peculiar point of view where the liberty of the subject is concerned. The Congress met and proceeded to pass resolutions fraught with serious and, in some instances, incalculably grave possibilities. First and foremost the members present resolved not to take part either in any government commissions or in carrying out the decisions of any commissions appointed to inquire into the suspected epidemics of cholera or to deal with other medical matters. The rest of their action may be gathered from the terse wording of a Reuter telegram, which ran as follows:—“They resolved that it was impossible to exercise their profession under the present political conditions, and that it was necessary to convene a National Assembly on the basis of universal suffrage without distinction of sex, religion or nationality. The immediate cessation of the war was also demanded.” When a message of this kind is sent by a humane profession it is indeed time for the autocrat of the Russias to set his house in order. The fate of previous national protests, however, has not been encouraging. *Quem deus vult perdere, prius dementat!* Possibly the Czar will shut his ears to the protests of a learned profession as he did to the workmen of St. Petersburg when they laid their petition at the feet of their “Little Father.” Although there is nothing in the United Kingdom resembling the terrorism of irresponsible tyranny that holds Russia in its grip, there is, nevertheless, far too much of the spirit of autocracy in the government of the medical profession in our own country. The General Medical Council is a body entrusted with the government and the safeguarding of the medical profession. It is autocratic, it is non-representative of the citizens who are taxed for its support—two conditions that might well exist in broken-spirited and enslaved Russia. As a concession to the modern principles of democratic government by representatives of the governed persons who find the money, a few “direct representatives” of the profession have been appointed. The latter, however, number five out of thirty-five, the rest being nominated by various corporations and by Government. A democratic reform of the constitution of the Council would probably be satisfied by reversing the existing ratio of direct and indirect representation. Anyway, it is a matter of vital importance to the future prosperity of the medical profession. Recently marked attention has been paid to the question in Ireland. Of the Irish representatives six represent medical schools and corporations, one is a Crown nominee, while one is elected by Irish practitioners. That is to say, the gentlemen whose registration fees support

the General Medical Council are staved off with a single vote on that body, whereas seven votes are allotted to Government and to medical Boards who do not contribute a single penny to the Council. The matter has simply thus to be stated in plain terms to demonstrate its unfairness and indefensibility. Some hope still remains that medical men of the United Kingdom will one day pluck up courage and energy enough to assert their right to manage their own affairs independently of vested interests in the shape of qualifying corporations and Crown nominees, all at the mercy of a non-elective and unsympathetic Privy Council.

A SPURIOUS MEDICAL DIRECTORY.

A WORK has been published during the past week which is described on its title-page as "The Irish Medical Directory." Its preface commences as follows:—"The Irish Medical Association have great pleasure in placing before the Profession, and the public generally, a new Irish Medical Directory which will, it is hoped, supply a long felt want, and take the place of that old Irish Medical Directory which was destroyed by fire some years ago." If we were explaining to "the man in the street" what the foregoing sentence means, we should proceed somewhat in this manner:—The Irish Medical Association is an old Society composed of honourable men, and established with the object of promoting the prestige, the solidity, and the welfare of the medical profession in Ireland. The medical profession is one of the most ancient and honourable professions to which a man can belong. It includes within its ranks men of all grades of society, it is governed by the laws of the land, by written rules, and by unwritten etiquette. A medical directory is a book in which is printed the roll of the medical profession, and in which each name is followed by the qualifications, by the appointments, and by a short record of the literary work (if any) of its owner. The Irish Medical Directory *was* such a work, dealing with the medical profession in Ireland. Doubtless, we should continue, this new Directory, which the Association is presenting to the public, will be of a similar character. The man in the street, however, opens the book and studies its contents, and what does he find? Those of our readers who live in Ireland can answer the question for themselves. Those who live elsewhere will find it difficult to believe that what we are about to state is true. If the sentence which we have quoted from the preface is correct, the Irish Medical Association has bestowed its name and its sanction on a work which is absolutely misleading alike to the medical profession, the public, and the institutions and business firms which have been induced to advertise in its pages, and which is moreover opposed to all the dictates of medical etiquette. This so-called *Irish Medical Directory* contains a list of the names of the members of the medical profession. Some of these names are printed in

large type, and are followed by the qualifications, appointments, &c., of their owners. The remaining names, and these constitute the vast majority, are printed in small type, and after them does not even appear sufficient to indicate that their owners are members of the medical profession. The former set of names correspond with those of the members of the Irish Medical Association, the latter set with those who are not members. The work is called "The Irish Medical Directory," and it bears the announcement that it is published by the Irish Medical Association. It is perhaps hardly necessary to explain the reason of our objection to the work in question; but to the uninitiated it may be as well that we should point out that this so-called medical directory commences with the statement that "Members of the Irish Medical Association are printed in black type." (*sic*) this being the only statement made to indicate any difference between their names and those of the remainder of the profession. We therefore are justified in assuming, and the public at large will believe, that no other difference is made. Consequently, when it is found that a "Directory" which is advertised as a "reliable and accurate record of the profession in Ireland" contains some names to which are appended qualifications and appointments, and other names to which neither is appended, we must again assume, and the public at large will believe, that, as the work is a "reliable and accurate record," the men in the latter class possess neither qualifications nor appointments. It is this which constitutes a gross misrepresentation of the non-members of the Association to the public who are offered a "reliable and accurate record." We have said that this "Directory" is contrary to medical etiquette. Medical etiquette forbids that a medical man shall advertise to the world his attainments to the detriment of his professional brethren. What is thus forbidden to the individual is equally forbidden to a group. The Irish Medical Association has no more right to advertise, in a work printed for public sale, the professional attainments of its members than has an isolated member of the Association. Custom has sanctioned the announcement of professional attainments in a directory, but a directory is impartial and affords a fair field to all. Suppose that the Universities, the Royal Colleges, or the Academy of Medicine produced a work on similar lines, and called it "The Irish Medical Directory," what would be thought of their honour, their dignity, their sense of responsibility as representative bodies? Surgeon-General Evatt might then with justice initiate his campaign. Truly, in the last few weeks the character of the medical profession in Ireland has been dragged into the mire, as it has not been in many decades past. And by whom? There is one gleam of hope in the whole wretched business. The Irish Medical Association has disowned Surgeon-General Evatt's insults, and we are credibly informed that, in spite of the opening paragraph which we have

quoted, the proof sheets of this book have not been seen even by its Committee of Council, and that the Association is unaware of its character. This, if so, and we earnestly hope that it is so, is a lame excuse, but drowning men clutch at straws, and those who view with deep concern the present *impasse* look eagerly for any support which can float the credit of the Association into safety. We urge, nay, we entreat, the Association, by the memory of its past traditions and by the hopes which the prospect of its future work has inspired, to dissociate itself from a dishonourable attempt to exploit the few at the cost of the many, and to repudiate a publication the like of which has never been issued by a body of professional men.

UNION OF LONDON MEDICAL SOCIETIES.

THE proposal, often made and as often dropped, of uniting in one comprehensive body all the heterogeneous medical societies that now seek to attract members is once more to the fore. The two questions that naturally arise in considering the project are: Is such union desirable? and, if desirable, is such union practicable? The first raises the further question as to what are the functions of a medical society? These, in the main, we conceive to be threefold. First, to bring together medical men of all shades of opinion to consider the problems of the moment from every point of view, and by discussion to arrive, if not at agreement, at least at some practical *modus vivendi*, pending further enlightenment. Secondly, to advance medical knowledge throughout the whole profession by showing where that knowledge needs supplementing, and by spreading through the reports of the debates information as to current opinions proved by those best qualified to judge. And, thirdly, to promote good feeling and good fellowship among members by personal contact, so that asperities engendered by newspaper controversies and ill-judged partisanship of adherents may be removed by personal meetings and discussions in which each of the parties is enabled to recognise the good intentions and scientific enthusiasm of the other. Now, if we are correct in our definition of aims, the question of the desirability of such union has answered itself. The more members there are to a society, the more those members are brought into contact, the more widely available the reports of the discussions become, and consequently, the more useful is that society. The point that we would thus wish to drive in is that the medical societies of London, though they must remain largely officered and worked by consultants and purely scientific investigators, should become available for the general practitioner. At the present time such is notoriously not the case. A certain number of general practitioners and provincial physicians and surgeons attend society meetings in London, but to the vast bulk of the practitioners in the country the work of the societies is a dead letter. From the point of view of the diffusion of medical knowledge this is a vast pity, and from the point of view of the collation of experience a distinct

loss. The working out of the theories of the scientist and the after-history of the treatment of the consultant pertain almost exclusively to the general practitioner, and by his amplifying and correcting experience the latter can afford a wholesome check on the arm-chair views of the doctrinaire or the immature fledglings of an impetuous innovator. To open the whole field of medical advance and discussion to the general practitioner and to place him in a position to keep thoroughly abreast of all change in views on important questions is an advantage for which it is worth while sacrificing a good deal. But the desirability of amalgamation does not end in merely widening the net of membership. There is no gainsaying the fact that much of the time of the societies is frittered away at present. Communications and papers are spasmodic and without relation to each other, whilst half a dozen societies frequently cover the same ground as each other. In a united society it would be possible to co-ordinate work and to define aims, so that progress could proceed on carefully-planned lines. Collective investigation such as has been undertaken occasionally in the past might be regularly organised, so that at the end of each year clear advances in the positions could be shown. Moreover, full-dress debates on the questions of the moment—such as that recently held by the Medico-Chirurgical Society and the annual debate at the Chelsea Clinical Society—would become regular features, and by their means definition, fixity, and clarification of opinions would be secured. Turning next to the question of practicability, the path is not quite clear. There is a deeply-rooted love of "muddling through" hidden in the breast of Englishmen, and ideas involving change are always certain of opposition from no inconsiderable section. First, there are the traditions and associations, and even the prestige of the old societies to be allowed for, and we shall be surprised if there be not many of the older hands who are unwilling to break with them. Moreover, certain opposition will be met with at the hands of those who make societies stalking horses for their own aggrandisement rather than channels of good to others. Faddists, one-idea men, and mere self-seekers would find the opportunities for self-magnification considerably reduced in a united society, and with vigilant committees of reference a good many of the papers that now appear in "Transactions" would gently give way to those likely to be of more enduring value. Hole-in-the-corner men will always exist in every section of society, but in a Royal Academy of Medicine they would find their own level, if such an academy were made what it should be, namely, a place for serious study, and not a mere club for passing pleasantries and talking ephemeral "shop." In point of fact, by the union of the medical societies in London the lacuna in medical life that the Royal Colleges were designed to fill, and that they have steadily refused to recognise, might be bridged, to the great advantage of medical science and good

fellowship. Financially, we see no difficulty. One of the worst features of the present jumble is that to keep in touch with the different departments of knowledge a man has to join several societies at one, two, or three guineas each. With a large membership a subscription of three guineas for town, and two guineas for country members should amply cover expenses. The real obstacle to amalgamation will be met with in sectional interests and personal ambitions; if the good of the profession alone be consulted the societies would link themselves up to-morrow.

Notes on Current Topics.

Testimonial-mongering.

ONE of the primary rules of the business of advertising is that if you advertise long enough—whether your wares be pills for earthquakes or obsolete encyclopædias for gullible gowks—testimonials, free, spontaneous, and laudatory, will begin to pour in. Minatory communications from disappointed dupes find a last resting-place in the waste-paper basket, but the flattering epistles of the aforesaid gowks remain for filing in the office and future publication in current "literature." It is not always so easy to determine the origin of the scientific reports that are attached, under the sign and seal of "experts," to flamboyant descriptions of Johnson's Eyberene for the Eyebrows or Brown's Pilprogress for Bunions. A little healthy light on this parasitic trade of testimonial-mongering has been let in by Mr. Labouchere in a recent number of *Truth*. A person who had taken out a patent for a preparation for the hair with a view to placing it on the market received the following letter:—

171 Brixton Road, London, S.W.

March 11th, 1905.

DEAR SIR,—Would you care for me to provide you with an excellent trade certificate as to the value, purity, and harmlessness, &c., of your "— for the hair"? If so, the fee would be *One Guinea*. I will strongly recommend the preparation. Best wishes,—Yours sincerely,

A. B. Griffiths.

The paper on which this was written was headed:

"Dr. A. B. Griffiths,
Ph.D., Hon. D.Sc., &c.,"

followed by claims to be member of a number of foreign Chemical Societies, Consulting Chemist to National Amateur Gardeners' Association, Lecturer on Chemistry to the Hairdressers' Guild, late Lecturer on Metallurgy at the National Dental Hospital. Also descriptions of himself in the light of Analytical Chemist, Bacteriological and Agricultural Expert; and the author of many books. Perhaps the most interesting of these claims, beyond that of being Lecturer on Chemistry to the Hairdressers' Guild—an office we confess we did not know to exist—is that of Agricultural Analyst for the County Soke of Peterborough. We had thought that "Sokes" were as obsolete as wapentakes for anything but antiquarian purposes, so that it comes with some-

thing of a shock to find the authorities of these ancient circuits are so much up to date as to appoint Agricultural Analysts. We wonder whether the acceptance of such an appointment entitles the holder to the privilege of socage, and whether such socage is free and honourable, or "villein socage, when the service, though certain, was of a baser nature." Is it not possible for the Society of Analysts, for the credit of an honourable calling, to take this matter up?

Hospital Abuse in America.

IT is interesting to learn that the same serious questions relating to hospital management crop up in the States as at home. It seems that even among the citizens of that prosperous country there are found many who, though of independent means, are quite willing to accept medical relief as a charity, although they would shrink from accepting doles of food and drink. In fact, it appears that in Boston, probably *per capita* the richest city in the world, hospital abuse is as rife as in London. In spite of the greater wealth of Boston in comparison with New York or Philadelphia, the percentage of charity patients to the total population is greater, and neither in New York nor in Philadelphia can it be maintained that hospital relief is strictly limited to the classes for whom it is designed. So serious has the situation become in Boston that the profession there have found it necessary—following the example recently set in this country—to meet in conference in order to adopt some plan to reform the present methods of hospital administration. The suggestion was made that all patients should undergo examination as to their suitability for hospital treatment—a course so obvious that it is astonishing that it is not followed in every hospital in the world. Another abuse of which the Boston profession complain is the custom of the Massachusetts General Hospital and other lesser institutions, in maintaining private rooms for the reception of well-to-do patients, to whom the attending physicians and surgeons are forbidden to charge a fee.

Inquest Fees.

A GENUINE and long-standing grievance exists with regard to inquest fees to medical men, and it is almost incomprehensible how such a gross injustice as the withholding of payment from medical officers of hospitals who are called to do *post-mortems* and give evidence before the coroner can have remained unrectified for so long a period. Perhaps of all the pettifogging dodges to escape paying for medical advice, this provision of the Coroners Act is the meanest. The only shred of comfort forthcoming is that most of the coroners themselves and many juries recognise the legitimate claims of the profession in this matter, and we note with satisfaction that at an inquest held at Crawley the other day a rider was added to their verdict by the jury saying:—"In view of

the Employers' Liability Act having been passed since the Act debarring medical men from fees for inquests and *post-mortem* examinations held on patients dying in public institutions, we feel that the extra responsibility thrown on medical men entitles them to fees in all circumstances." The case that drew forth this expression of good feeling was not different from a dozen others that occur every day, except that it involved a most responsible decision as to liability under the Employers' Liability Act. The subject of the inquest was a workman who had fallen off a ladder during building operations, and who was taken to the local cottage hospital, where he subsequently died. The *post-mortem* revealed that the cause of death was cerebral hæmorrhage, and therefore that the builder was not liable for compensation to the widow, as he might have been found to be had there been a fracture of the skull. For giving up his day, making a prolonged examination, and coming to this responsible decision, the medical officer, Dr. Matthews, received not a penny from a grateful community. Until this anomaly is rectified—and rectified it surely must be if only brought to notice in the proper quarter—we believe that injustice may be avoided by the jury voting a special recommendation that a fee should be paid for extraordinary expenses, and this recommendation being received and approved. The plan is at least worth trying, for nothing but good can come of letting people in authority know of this gross imposition on a long-suffering and much-cheated profession. ▮

A Student's Right to Graduation.

A LAWSUIT of a somewhat curious nature has recently taken place in America, being instituted by a medical student who had been refused a diploma by the Barnes Medical College of St. Louis. It appears that the student in question had fulfilled the necessary course of study, and satisfied his examiners in the various exercises, but owing to unsatisfactory reports of his moral character the College refused to admit him to a degree. The student thereupon applied to the Courts for an order to compel the College to confer the degree, and this order was granted by the lower court. On appeal, however, the decision was reversed, and judgment given for the College. On the point of law the College seems to have been on quite safe ground, as they openly state that they require as a condition for graduation "a good moral character, which includes unexceptional conduct while at college." We believe that in most universities on this side of the Atlantic a similar condition is in force, and by this means it is possible to exercise discretion as to the admission of candidates to degrees. Indeed, in some universities it is the rule that no student who is in debt can graduate, and the graduation ceremony contains an invocation in Latin to debtors to enter a protest if they wish to do so. At any rate, it is quite obvious that a university should not merely have the right of refusing its degree to persons morally unsuitable, but should also

have the power of depriving unworthy *alumni* of their position as graduates.

Care of Consumptives in Dublin.

It is satisfactory to find that the Public Health Committee of Dublin are at length rousing up to some activity in regard to the problem of the care of the consumptive sick in that city. They have pointed out in a recent report that for the great majority of such patients there is no hospital accommodation. Many are in the Union hospitals, and a few in special hospitals for incurables and dying persons, but the enormous number of the consumptive poor are tended till death in their own homes, surrounded by their own families. It is obvious that such a condition leads to infection being continually renewed throughout the community, while it is profoundly injurious to the unfortunate patient. The obvious method of dealing with the situation would be the establishment by the municipality of public hospitals for tuberculosis, into which patients in any stage of the disease might be admitted. In the present state of finance in Dublin, unfortunately, the large expenditure required for such a scheme renders it impracticable. The Medical Officer of Health has therefore suggested to the general hospitals in receipt of Corporation grants the establishment of one or two wards exclusively for consumptive cases, and at least one of the general hospitals has adopted the suggestion. It may be said at once that the hospitals of Dublin are, both by structure and site, unsuitable for the treatment of tuberculous cases. At the same time, many of them have empty wards at their disposal, in which doubtless consumptive patients can be tended better than in their own miserable homes, and so long as the arrangement is regarded solely as a makeshift, it is perhaps the best available under present circumstances.

Sight-Testing by Opticians.

A DETERMINED effort is being made by the General Board of Opticians, representing the Spectacle Makers' Company and the British Optical Association, to defeat the clause in the Medical Acts Amendment Bill now before Parliament, which seeks to confine the examination of the eye for errors of refraction to medical practitioners. A deputation waited on Mr. Alban Gibbs, M.P., and Sir William Hart Dyke, M.P., at the House of Commons to urge that the *diplomats* of the two bodies who have been examined in sight-testing might be allowed to continue to practise. It appears that these must present three types of opticians: those who let their customers choose their own spectacles, those who test the sight by lenses, and those who only make glasses to medical prescription. It is proposed that the practice of the second class shall now be recognised as legal, and we are sorry to see that Mr. Gibbs in a subsequent interview expressed himself in favour of the proposal. His information, however, seems to be defective, for he says he does not see how everybody is to be made to go to an "oculist"

and to pay one or two guineas for having his sight tested. We can inform Mr. Gibbs that he is quite mistaken if he thinks the medical profession are in favour of any such impracticable proposal. The rich and well-to-do who wish to consult a West End ophthalmic surgeon would, of course, pay his fees, but all over the country there are medical men with the requisite knowledge who are willing to examine the sight and prescribe glasses for five shillings, seven-and-sixpence, or half-a-guinea, according to a patient's means and ability to pay. For the very poor there are in towns large hospitals with ophthalmic departments, and in the country there is never any difficulty in getting medical advice, free or no fee. To hand over the testing of sight to spectacle-makers is perfectly unnecessary, and the agitation to that end is a mere selfish attempt on their part to swell their incomes. The danger of putting people with no knowledge of pathology or medicine to prescribe glasses for the eye need not be dilated upon in a medical paper, for every doctor knows that defects of vision are frequently only symptoms of grave general diseases whose very names the optician would not know if he heard them.

History of the Laryngoscope.

THE recent celebration of the jubilee of the introduction of the laryngoscope, happily coinciding with the hundredth birthday of its venerable inventor, has naturally turned attention to the history of the instrument itself. And although the entire honour of the discovery of the laryngoscope, with whose principles we are to-day so well acquainted, rests with Señor Garcia, yet he had forerunners who just failed to reach the point attained by him. Thus, quite early in the last century Bozzini invented an instrument for "illuminating the cavities of the living animal body." He suggested its application to the larynx, and, though his instrument was too clumsy to be of practical use, it made use of the very principles of reflection afterwards adopted by Señor Garcia. In 1829, Dr. Babington exhibited to the Hunterian Society a "glottiscope" very similar to the laryngeal mirror at present in use. In 1840, Liston attempted to view the larynx "by means of such a glass as is used by dentists on a long stalk, previously dipped in hot water, introduced with its reflecting surface downwards, and carried well into the fauces." A few years later, Landen and Avery made attempts by various implements to get a view of the larynx, but though they and some of the others we have mentioned may have got flying glimpses of the vocal chords, it remained for Manuel Garcia, in September, 1854, to watch with ease and delight for the first time the movements of that most wonderful of musical instruments, the larynx.

Hospital Reform and the Edinburgh Royal Infirmary.

A GOOD deal of discussion has been caused among the profession in Scotland by the refusal of the Managers of the Royal Infirmary to send

a representative to the conference on hospital reform recently held in London. It appears that the Managers on seeing the resolutions to be discussed were of opinion that while some of the suggestions contained therein were already in force in the Infirmary, the adoption of others was precluded by the wording of the Charter. This may or may not be so, but at any rate, the Managers would not have bound themselves in any way by being represented at the Conference, and the assistance and advice of such an experienced charity as the Royal Infirmary could not fail to be of material help to other institutions. Moreover, as our contemporary, the *Scottish Medical and Surgical Journal*, points out, the Managers seem inclined to place an undue importance on the wording of the noble motto, *Patet omnibus*, placed over their door. For long the Managers have very properly limited the meaning of this term by certain qualifications. Indeed, if taken literally, it would mean that the Infirmary was a common lodging-house. Nor is the Infirmary open to all the sick in need of hospital treatment, for in no event is a case of infectious disease, such as scarlatina or typhoid fever, admitted to treatment within its walls. If, then, the Managers have properly limited the scope of its functions in one direction, they have no excuse for not doing so in another equally important. The Managers are only properly carrying out their charter and their motto if they see that the Infirmary is kept really open to the poor and needy, whose only qualification is their sickness and their inability to pay for treatment elsewhere.

The Lincoln Typhoid Outbreak.

HAPPILY some signs of abatement are recognisable in the serious outbreak of enteric fever that for some time past has devastated the ancient city of Lincoln. For all that, a considerable, although lessening, number of new cases is still reported every week. Among fresh invasions, that of the local workhouse has been reported. Some eight or ten inmates of that institution have been attacked by the malady. Directly or indirectly, there can be no reasonable doubt that the origin of this particular infection must be attributed to the contaminated town water supply. It is somewhat difficult to understand how the workhouse inmates can be affected in that way. The notoriously bad water supply of Lincoln has been under the notice of the Local Government Board more or less for the past quarter of a century. During that time the local workhouse has been the victim of at least one of the numerous typhoid outbreaks with which the inhabitants of the district are only too painfully familiar. If the Local Government Board have been unable to induce the Lincoln town authorities to do their duty and furnish pure water to the townsfolk, they cannot plead the same excuse with regard to the workhouse. It is the bounden duty of the Local Government Board to protect the water supply of a Poor-law

institution. Similarly, it is the duty of the War Office to protect the soldiers in the local barracks from typhoid-laden water. Both barracks and workhouse have been more than once invaded by enteric fever. By placing one of the French water sterilising apparatus, known as the Vaillard-Desmaroux or Salvator system, both Local Government Board and War Office could at small outlay secure absolute safety from water-borne disease to those under their charge.

"Mild" Fevers.

THE average journalist who wishes to minimise the report of an epidemic is wont to prefix the epithet "mild" to the name of the infection. There could hardly be imagined a more misleading or dangerous attitude on the part of a writer of matter for popular consumption. As every medical man knows, mildness is a quality that applies to the individual invasion, but not to the disease itself. Thus, small-pox is small-pox and measles is measles, but attacks of either malady may be mild, moderate, or severe. The so-called "mild" attacks of an infectious fever are just as "catching" as the severe. The "mild" case in one person may therefore communicate the original fever in its severest form to another individual, and *vice versa*. How often has a patient infected with "mild" diphtheria spread the disease broadcast! In point of fact, these mild attacks are far more dangerous to the community than those of greater severity, inasmuch as sufferers are more difficult to keep in one place, and measures of prevention are less rigorously carried out. By all means let the public be educated to the fact that "mild" infectious attacks are deadly centres of infection no less than those that run a more rapid and violent course.

Religious Revivalism and Mental Balance.

RELIGION, broadly speaking, furnishes mankind with rules of conduct. In this way, religious guidance, based on high moral ideals, becomes one of the greatest of all agencies for human advancement. Of the many forms of religion that have dominated the world, some have been sane and some hysterical. The religion that is sane in its methods and pure and lofty in its ideals must appeal to the sympathy of the lover of humanity, no matter what his own particular creed may be. Members of the medical profession are brought into close contact with believers in every creed, often under circumstances that throw individual religious views into strong relief. Medical men, therefore, of all men, should be able to regard differences of creed with tolerance and sympathetic understanding. They cannot, as a profession, overlook the fact that some at least of the more demonstrative and fantastic forms of religious exercise are emotional and hysterical expressions of a more or less distempered intellect. It is well to bear that fact in mind in these days of world-wide religious revivalism. Only last week it was reported that a young Welsh revivalist

asserted that two ministers in a Liverpool audience were hypnotising him and in that way wrongfully influencing his actions. On being challenged by two ministers present, he abruptly left the hall, and the meeting "broke up in confusion." In any other walk of life there can be little doubt that, medically speaking, the incident would suggest to any experienced physician skilled in mental disease the desirability of a careful investigation into the whole matter.

The "Bazaar" and the Appendix.

"WHEN in doubt," ran the old maxim for inexperienced whist-players, "play trumps"; in these days of Bridge the phrase has doubtless been altered to "When in doubt, look at Dummy." In medical matters, a similar change has come o'er the spirit of the dream, for when in doubt about his health the patient now seems to go, not to his family doctor, but to the *Bazaar*, *Exchange* and *Mart*. We were amused, though not much instructed, to read in this versatile journal on March 31st, a letter from "Appendix," inquiring the cause of his ailment and the editorial reply thereto. "Appendix" had just passed through an attack of the fashionable complaint, and was anxious to know if he did wisely in not having the offending member removed, and further how he should avoid similar troubles in future. Having regard to the function of the paper, we are surprised that he did not offer to exchange his troublesome appanage for a Persian kitten or a triangular Cape of Good Hope stamp, but perhaps he was only sounding the editor as to the chance of a bargain if he decided, as the result of his advice, to place himself in the surgeon's hands. The editor, however, did not scent business, for he availed himself of the hospitality of a column headed the "Housekeeper's Room" to deliver a long reply, evidently transcribed with the minimum of discriminative intelligence from an old edition of Quain's "Dictionary of Medicine," or some similar reference book. From this screed we gain the interesting information that the literature of appendicitis was "not voluminous until after the King's attack; but since that memorable event, which might have been fraught with such serious consequences to the Empire, a flood of books and pamphlets, of more or less interest and value, have made their appearance upon it, that by the King's surgeon-in-chief rightly taking precedence of the rest." This means, we suppose, that the writer was unacquainted with the literature of the subject till his Majesty's illness brought the complaint to his knowledge. That we can readily believe. Fortunately, the editor does not venture on any direct suggestions either as to how to avoid an attack or how to treat one already inaugurated; in fact, several of his precepts (thanks to Quain) are remarkably sound. Out of the earth came forth meat; out of the strong

came forth honey; and out of the *Bazaar* came forth medical advice—a of a kind.

Violets for Cancer.

PERHAPS the silliest of cancer cures that have found their way into the lay press is the "violet cure." Some time ago a case that was boomed for all the copy it would make went the rounds of the press, and after creating a nine days' wonder it was shown on medical testimony that the patient had never had cancer at all. Since then we have waited, without impatience, to hear of numbers of cases of malignant disease in which violets have been tried and found wanting. Up till now the violets have been hiding their virtues in the modest way violets have. But they have appeared once more in the columns of our contemporaries, and this time with some appearance of authority, for their comments are called forth by the report of a case in the *Lancet*. The patient in question was thought in the clinical diagnosis of four medical men to have cancer of the tongue, and removal was advised. There does not appear to have been any pathological examination of the growth, but none of the lymphatic glands in the neighbourhood were enlarged, and the lesion seems to have strictly localised. The patient preferred to try the effect of violets, and he started using an infusion of violet-leaves both as a beverage and as an application to the outside of the neck. Whether from the internal virtues, or from the absorption of the active principles through the unbroken skin, or from that physician's ally, the *vis medicatrix natura* came the necessary succour is not apparent, but at any rate the ulcer on the tongue began to heal and the man's health to improve. How stupid and prejudiced doctors are! Because the knowledge of the anti-malignant properties of violets came through non-professional channels they refuse to quit cutting and hacking cancer patients about, and to give them pleasant drinks and sweet-smelling fermentations! But medical men who are brought more into contact with flesh and blood and the realities of life than they are with printer's ink and sensational journalism know that an awful responsibility rests on them if they listen to the vapourings of irresponsible scribes, and do not avail themselves of surgery as the only hope that presents itself to the cancer-stricken patient. If any of these writers induce their readers to put off extirpation with the knife while they dally with violets or any other nostrum, we should not care to put ourselves in their place when—too late—the truth is revealed.

The Legislature and the Drug Habit.

MEDICAL men know only too well from experience the terrible evil to the community arising from the habit of taking narcotic drugs. Of recent years there is good reason to conclude that this pernicious fashion has increased to an alarming,

nay, indeed, to an appalling extent. The medical profession, therefore, will hail with acclamation any attempt to cope with one of the most fatal and insidious of human weaknesses by the indirect intervention of the legislature. At a recent meeting of the Council of the Pharmaceutical Society, it was decided to ask the Privy Council to sanction the inclusion of a number of drugs within the provisions of the Pharmacy Act, 1868, so that they might be scheduled as poisons under that Act. The drugs it was proposed to deal with were: acetanilide, cocaine and its preparations, picrotoxin, digitalis and its preparations, sulphocyanide and iodide of mercury, soluble salts of oxalic acid, strophanthus, and sulphonal. If the foregoing substances be in future labelled "poison," and their sale limited to qualified chemists and druggists, and vended under certain strict limitations, the drug habit is likely to be curtailed considerably in some of its worst features. One result will be to control the sale of various proprietary medicines that are now permitted to play havoc with the well-being of the public. Several prominent Coroners have with laudable persistence called attention for many years past to the monstrous abuses arising from these proprietary poisons. Hitherto their voices have been those of men crying in the wilderness.

A Challenge to Mr. Coroner Troutbeck.

THE Westminster Guardians recently received a complaint from Mr. Coroner Troutbeck to the effect that a divisional surgeon of police, Dr. Percy Edmunds, had refused to give information respecting the death of a man, and had referred his officer to Dr. Freyberger. Dr. Edmunds sent a letter of explanation to the Guardians, in which he said that in his capacity as Registrar of Deaths he sent the usual notice. "I offered," he went on, "to supply all further information to the coroner if he gave me an assurance that I should be subpoenaed in the usual manner for the inquest if he considered an inquest necessary. I have fulfilled all my duties as district medical officer and as registrar fully and properly. The coroner has no power to demand information privately from anybody. The dilemma is only natural, and is likely to occur, considering that Mr. Troutbeck has broken long-standing custom and etiquette, and insulted and discarded the medical men practising in the City of Westminster. The remedy for the dilemma is very simple, and is in his own hands. The public fees for making autopsies and giving evidence at inquests should be diverted from the pockets of Dr. Freyberger into the pockets of the medical practitioners who are called in to see the circumstances and surroundings of sudden and suspicious death." It is well that some members of the medical profession are not afraid to take up the cudgels in defence of their rights.

PERSONAL.

It was stated at the recent annual meeting of the London Mendicity Society that the King proposed

to increase his annual subscription from fifty guineas to seventy-five guineas.

PRINCESS CHRISTIAN last week attended the annual general meeting of the Ladies' Association of the Hospital for Women, Soho, at the residence of Sir Marcus Samuel.

PRINCESS ALEXANDER OF TECK has consented to become President of the Ladies' Samaritan Society, National Hospital (Albany Memorial), Queen Square, Bloomsbury.

SIR DONALD CURRIE has sent £500 to the Duke of Marlborough, the chairman of the committee that is arranging the banquet over which Mr. Chamberlain will preside on behalf of the London School of Tropical Medicine on May 10th.

THE Viscount Hampden has accepted a seat on the board of management of the National Hospital for the Paralysed and Epileptic.

It is now definitely arranged that the dinner to Dr. C. Owen Fowler, who was recently acquitted of charges brought against him in the Divorce Court, will be held on Thursday, May 4th, at 8 o'clock, at the Greyhound Hotel, Croydon. Tickets, exclusive of wine, 5s. each, may be obtained from Mr. C. M. Fegen at the Town Hall, Croydon.

LADY MALCOLM of Poltalloch, has presented one of the twenty-six ambulances for horses which will be provided in the Metropolis by Our Dumb Friends' League. These can be summoned by telephone, and the address is 118 Victoria Street, S.W.

HIS ROYAL HIGHNESS PRINCE CHRISTIAN OF SCHLESWIG-HOLSTEIN, Viscount Esher, and Mr. Alexander William Shipley have been appointed trustees for the new Windsor and Eton Royal Infirmary shortly to be erected.

THE King has conferred the Royal Red Cross upon Mrs. K. Boyd (*nee* Driver), in recognition of her services in tending the sick and wounded at the Volunteer Hospital at Intombi, near Ladysmith, during the late war in South Africa.

MISS AMELIA JANE BATHURST, of Eastbourne, has left the West London Hospital, the Princess Alice Memorial Hospital, Eastbourne, and the All Saints' Convalescent Hospital in the same town, the sum of £200 each.

At the annual meeting of the Metropolitan Hospital Saturday Fund at the Mansion House on April 29th, Dr. Latham will deliver an address on "Sanatoria for Workers." The receipts from workshops and business houses has reached £24,344.

THE festival dinner of the National Hospital for the Paralysed and Epileptic, Queen Square, London, which was to have been held on Thursday next, has been postponed owing to the continued absence of Lord Strathcona in Canada.

ON April 5th Lord Lister attained his seventy-eighth birthday, having been born in the year 1827. The medical world will unite in offering their illustrious colleague the heartiest congratulations.

DR. EDMUND L. HUNT, C.M.G., has been appointed a medical officer of the Medical Department of the Gold Coast Colony. Dr. Hunt took part in the war in South Africa, for which he received special recognition.

THE Czar has sent gold cigarette cases to the Hon. Dr. J. M. Atkinson, principal civil medical officer, and Dr. J. Bell, superintendent of the Government Civil Hospital, Hong Kong, in recognition of the services

rendered by them to the wounded officers and sailors of the Russian cruiser *Variag* interned for a time in the British colony.

DR. F. G. HOPKINS, Senior Medical Officer of Lagos, will act as Principal Medical Officer during the absence on leave of Dr. H. Strachan.

H.R.H. THE PRINCE OF WALES has appointed Mr. Hugh Mallinson Rigby, F.R.C.S., assistant surgeon to the London Hospital, to be one of the Surgeons-in-Ordinary to his Royal Highness.

THE only members of the medical profession on whom the distinction of LL.D. of the University of Edinburgh was conferred at the graduation ceremonial last week were Professor William Watson Cheyne, Dr. Hughlings Jackson, Dr. Augustus Waller, and Sir Arthur Conan Doyle.

THE presidency of the London Royal College of Physicians for the coming year will be settled on April 17th. Sir William Church has held the post for an unusually long time (since 1899) and is not likely to be re-elected. The choice probably lies between Sir William Broadbent, Sir Douglas Powell, and Dr. P. H. Pye-Smith.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

EDINBURGH.

GRADUATION CEREMONIALS AT EDINBURGH AND ABERDEEN.—The spring graduation ceremonials took place at the Universities of Edinburgh and Aberdeen on April 7th. In Edinburgh the honorary degree of LL.D. was conferred upon Professor Watson Cheyne, Dr. Hughlings Jackson, Dr. Augustus Waller, and Sir Arthur Conan Doyle, M.D. The other recipients of the honour were Lord Kincairney, one of the judges in the Court of Session, Sir Frank Younghusband, Sir George Elliot, and Professor George Gilson, Glasgow. The Address to the graduates was delivered by Professor Darroch, the new occupant of the Chair of Education. His address on "The Spirit and Aim of University Teaching" was an eloquent and stimulating exposition of the higher ideals of education. A university, he said, sought to train those who in after life are destined to become members of the learned professions to discharge the duties of their offices connected primarily with the security, the welfare, and the progress of the community as an ethical and spiritual body, and the peculiar characteristic of the various offices for which a university endeavours to fit the youth is that the discharge of those duties requires one essential—*viz.*, that the work should be performed with singleness of aim and sincerity of purpose. One thing which mainly distinguished the worker here from the worker in other fields of labour is that the efficiency of the work and the conscientiousness with which it is carried out depend, to a much larger extent than in other spheres, upon the personal character of the worker. And again, "the characteristic note, the true distinguishing mark of our university teaching, as contrasted with all other teaching, is, or ought to be, that here, if anywhere, you have been imbued with the spirit, not merely or chiefly of seeking knowledge for the sake of knowledge, but of doing the work for the sake of the work, so that hereafter 'ye may not be like unto servants who minister to their masters upon the condition of receiving a reward, but that ye may be like unto servants who minister unto their masters without the condition of receiving a reward, and so that the fear of heaven may be ever upon you.'" At Aberdeen no members of our profession were among those who received honorary degrees. The degree of LL.D. was conferred on Professor Bury, Cambridge; Mr. Thomas Hardy, the author; Lord Reay, Mr. John Theodore Merz, D.C.L., Newcastle-on-Tyne; Maarten Maartens, and others. The customary address was delivered by Principal Lang.

GLASGOW.

ANDERSON'S COLLEGE, GLASGOW.—Dr. R. Barclay Ness has been transferred from the Chair of *Materia Medica* to that of the Practice of Medicine, vacant through the lamented death of Dr. R. Stevenson Thomson, who was an ideal teacher, and had a large class composed of a considerable number of university students. Dr. Ness will be peculiarly fortunate if he succeeds, as we hope he may do, in maintaining the high standard of teaching of his gifted predecessor.

GLASGOW UNIVERSITY.—APPOINTMENT OF ASSESSOR.—There was a large gathering of the above Council in the Bute Hall on Wednesday afternoon, the 5th inst., at the half-yearly meeting. Mr. Henry Erskine Gordon, of Aikenhead, Assessor to the Chancellor, occupied the chair. The number of members present was unusually large. In opening the proceedings the chairman said that he felt they ought to authorise the Business Committee to form a minute expressing their sincere regret at the death of the late Assessor, Sir John N. Cuthbertson, and that an extract should be sent to his relatives. Sir John had taken a very deep interest in educational matters in the city, and had the love and esteem of everyone with whom he came in contact. This proposal was unanimously agreed upon. Dr. John G. Kerr, of Allan Glen's School, then proposed Dr. John Hutchison, rector of the High School and Convener of the Business Committee of the Council, as Assessor. He thought Dr. Hutchison would make an ideal representative. He had endeavoured for thirty years to increase the welfare and utility of the Council, for ten years he had worked well on the Business Committee, and for other nine he had given faithful service to the committee in connection with the finances and statistics. He had been Convener of the Business Committee during the last seven years, he had had great experience in everything connected with education, and he had a keen interest in the advancement of the university, and in all that tended for the progress and prosperity of Glasgow. Dr. James Finlayson seconded the motion. The other candidates were the Rev. Dr. John Smith, chairman of Govan School Board, and Mr. Charles Ker, C.A. Dr. Hutchison was elected by an overwhelming majority over the total votes given to the other candidates. In a few words Dr. Hutchison thanked the Council for electing him as their representative to the University, and he would do his utmost to help forward their *alma mater*. Owing to the amount of time taken up by these proceedings, Sir James King moved the adjournment of the meeting till the following Wednesday for the transaction of a considerable amount of important business.

BELFAST.

BELFAST CORPORATION AND THE INSPECTION OF MEAT.—At the last meeting of the Belfast Corporation an interesting question arose concerning the inspection of meat. In the year 1900 the Corporation passed a by-law requiring all meat killed in the city to be inspected and marked when passed as fit for human food. The by-law has done much good, but has failed in one respect, for a number of butchers kill outside the city and bring in the meat. Consequently the Market Committee recommended a new regulation, requiring all meat brought into the city, except foreign meat coming by sea, to be accompanied by the head, heart, lungs, pleura, liver, kidneys, peritoneum, intestines, and spleen of the animal for inspection. A deputation of butchers pointed out, however, that this would mean carting the offal into the city and out again, and that when summer came they would be prosecuted for creating a nuisance, and, moreover, that it is a common practice to bring the choice parts of the meat killed in small country towns into Belfast for sale, where a better price is obtained. After much discussion the Corporation came to the conclusion that the proposed new regulation was unworkable, and rejected it.

PUBLIC HEALTH.—During the four weeks ending March 18th the following cases of zymotic disease were notified by medical men in Belfast:—Scarlatina, 35; typhoid, 28; erysipelas, 24; diphtheria, 19; simple continued fever, 17; small-pox, 3; membranous

croup, 2; and puerperal fever, 1. No case of small-pox has been notified in the last six weeks, so it is hoped the outbreak is at an end.

Correspondence.

THE CANCER PROBLEM.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—There is a curious propensity in humanity in general, when the presence of an evil is ascertained, to go hunting around for a cure, in preference to sitting down quietly to discover and if possible remove the cause of it. Every practitioner must be well acquainted with the patient who comes with a small ailment to be cured, and is visibly disappointed on being advised that abstention from certain courses is preferable to treatment with medicine. With this tendency in mind, it is of interest to consider the present attitude of the medical profession towards the cancer problem.

A distinguished French surgeon, Dr. Doyen, is discovering, and, indeed, claims to have discovered, a cure for cancer—though there is very little evidence to establish the validity of the claim.

At the present moment, in numerous laboratories, hundreds of strenuous investigators are examining the products of the cancerous process. While, however, it is doubtless necessary to thoroughly analyse such products, it is also worth while to consider the causes of their production—as it were, to begin at the beginning.

Cancer has been defined as "the result of an aberrated cell metamorphosis which has supplanted normal cell metabolism." Now, what is aberrated cell metamorphosis? It is the disorderly formation and progression of ill-developed cells—it is disease. What is normal cell metabolism? It is the orderly formation and progression of well-developed cells—it is health.

Granted that these definitions are correct and applicable, it then follows to inquire—what is the cause of aberrated cell metamorphosis? The answer is, too much, too little, or improper quality of the material from which the cells are formed, and bad hygienic surroundings. This eventually resolves itself into the food we take and the air we breathe.

Of the above factors, in my opinion, by far the most important is "too much material from which the cells are formed." In other words, we put into our bodies more material than is required for sustaining and replacing normal tissue change and waste. In plain language, we eat too much. It is obvious that the amount of material put into the body should exactly counterbalance the amount of material used up by it in the processes of growth, tissue change, and waste. Any excess is not only useless, but harmful. It is admitted that all food put into the body must be digested and assimilated, and that when there is excess, an immense strain is thrown on the organs in their efforts to counteract and get rid of the products of such over-assimilation. When these efforts fail, disease supervenes. Hence, Sir, the importance of our profession seriously considering the present position of the public in reference to their habit of feeding. If cancer is increasing, so is the prosperity of the nation, and the power of an immensely larger proportion of the people to indulge in an excess of food. Malaria was not banished from this country with the aid of microscopes and bacteriology, but by the drainage of swamps; and, while we should not relax our efforts in laboratories it may be that the solution of the cancer problem is not to be found there, but in our own homes, and by each man for himself in the dining-room.

I am, Sir, yours truly,

HOPE GRANT, F.R.C.S.E.

15 Christopher Street, Finsbury Square, London.

April 8th, 1905.

THE ALCOHOL QUESTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your correspondent, "A Former Lecturer on Pathology and Hygiene," appears to strike the nail upon the head in the statement as follows:—"It is to be hoped that Sir Victor Horsley's Committee will be a

truly representative one, and that their proposed syllabus will be submitted to the profession."

It is difficult, however, to conceive how a small minority of medical men, notwithstanding the eminence of one here and there, can be regarded as truly representative of a profession numbering so many thousands, and which, if put to the test, it might be found the great majority of were adverse to the extreme views of the total abstainers. There can be no doubt, I think, this latter party have long ere this discovered the hopelessness of their task in convincing the majority of individuals of mature age of the feasibility of their scheme; at any rate, during the recent passage of the Licensing Act the public press, both clerical and lay, as far as I could gather, regarded the Act as a *bona fide* effort to promote *temperance*, whereas teetotalers, whose aim is to abolish drink except as a therapeutic agent, were dead against it, simply on the ground that the legislature recognised the sale of alcohol as a moral and legal trade in a commodity which the public intended to be supplied with and had a right to.

I think I am correct in stating that owing to improved conditions in society, in which we all rejoice, intemperance has greatly diminished, certainly amongst the cultured classes. Whether this is due to the temperance party, or in spite of them, one cannot say. It is, however, difficult to explain how it comes to pass that the quantity consumed—making allowance for increase of population—has decreased, although much of this may be due to depression in trade. There is yet no disguising the fact that the quantity of alcohol still consumed exceeds that of yore. Surely, after all is said, some beneficial factor must lie latent in the "curse," otherwise the exhortations of the teetotalers who have held office for about six decades should by this time have done more to convince the world that their views are tenable.

It is from considerations such as these that the medical profession should recognise the importance of not allowing the extreme party erecting any unwarrantable prejudice in the infantile mind in our public schools until they have proved their claims before some independent and unprejudiced tribunal. There is reason, I fancy, in believing that the petition on the teaching of hygiene and temperance has had an exaggerated effect in the eyes of the public with regard to the views held by the profession as a whole, so much so that it seems to me the petition might have carried more weight if each of the 15,000 signatories had by some means denoted whether he was a total abstainer himself or otherwise.

I am, Sir, yours truly,
CLEMENT H. SERS.

Brighton, April 9th, 1905.

THE LINCOLN TYPHOID EPIDEMIC.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.
SIR,—The terrible Nemesis that awaits the neglect of modern sanitary law could not be better illustrated than by the plain, unvarnished story of the typhoid outbreak that is now devastating Lincoln. In the face of repeated warnings extending over at least twenty years the Corporation are still supplying citizens with hopelessly contaminated water. Panic-stricken before the overwhelming flood of disease and death recently distributed through their own water mains, the Corporation have clutched at any straw to help them out of their present strait. Rightly enough they have placed themselves in the hands of Dr. Houston and Dr. McGowan, two of the most distinguished authorities living in the special subject of water supplies. But the only comfort those gentlemen have hitherto been enabled to offer is miserably inadequate to meet the pressing needs of Lincoln. It will take years to secure a new and perfect water supply for the town. What is to be done in the meantime? Water has been brought from neighbouring systems in profusion, but that cannot go on indefinitely. The other chief thing has been to treat the water chemically with sodium hypochlorite. The fallacy of such chemical treatment, however, is fully proved by the

publication of a report from Drs. Houston and McGowan, showing that the samples of water collected from main taps between March 7th and 18th bacillus coli was present in 25 per cent. The examiners regard these results as "so satisfactory that they feel justified in reducing the dose of sodium hypochlorite." It is not easy to understand how satisfaction can be expressed with any method that allows one out of every four samples of tap water to be contaminated with living human bowel organisms. As a matter of fact, the abject failure of chemical treatment, to my mind, could not be more forcibly demonstrated than by this report. In your columns, Sir, you have several times adverted to the use of Salvator apparatus, invented by Vaillard-Desmaroux, and widely used in France for the sterilisation of drinking water supplies. If any town in France were afflicted in the same way as Lincoln it would have the whole of its water supply purified by the Salvator apparatus within a few days. As water experts, Drs. Houston and McGowan must know that this is the only scientific method yet invented of purifying drinking water on a large scale. Dr. Thresh, another great authority on water, has fully endorsed the claims of the French steriliser.

Meanwhile, Lincoln must go on consuming bacillus coli while salvation (and Salvator) lies at their gates in the shape of a simple scientific apparatus. Whatever responsibility may be in future established for the epidemic at Lincoln, you, Sir, at any rate, have done your duty in pointing out the only rapid and effectual means of rescue as yet known to modern science.

I am, Sir, yours truly,

A MODERN SANATARIAN.

Southsea, April 9th, 1905.

THE "IRISH MEDICAL DIRECTORY"—A DISCLAIMER.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—My name having been connected in such a way with the publication of the Irish Medical Directory as to prejudice my candidature as Direct Representative for Ireland, I find it necessary to state that I am in no manner responsible, directly or indirectly, for this publication.

Nor does any responsibility lie with the Council I.M.A., except laxness in not supervising its publication, as I am not aware the Council were ever consulted in the matter, or that the proof sheets were submitted to the Council, or that the Council ever gave any authority for its publication.

Nevertheless, I think the profession in Ireland should feel deeply indebted to the compiler for the great labour and trouble he undertook. No doubt when the unfortunate arrangement of the book is rearranged, its future editions will be highly appreciated.

I am, Sir, yours truly,

L. KIDD.

Enniskillen, April 9th, 1905.

[We welcome the statement of our correspondent that the Council of the I.M.A. is not responsible for the spurious directory which has been presented to the public. We doubt, however, that the majority of the medical profession who are described as possessing neither qualifications nor appointments will "feel deeply indebted" to the compiler and originator for his great labour.—ED.]

THE CHEMISTRY OF CANCER.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In view of the immense importance of the facts contained in Dr. Blumenthal's recent speech before the Berlin Medical Society in the cancer discussion, as reported in the *Berliner klin. Woch.* of March 27th, p. 373 *et seq.*, and in consideration of the circumstance that his results and those of his colleagues form an ample justification, were such needed, of the chief conclusions advanced by me in an article (*Lancet*, February 4th, 1905) upon the embryological solution of the cancer problem, I respectfully request you kindly to find space in your journal for my translation of Dr. Blumenthal's remarks, and for this letter.

Among other things he and his colleagues have found that trypsin is a complete solvent for cancer-cells. I may add that, as doubtless you are aware, Dr. John A. Shaw-Mackenzie and myself had independently and for different reasons reached the conclusion that trypsin was the substance capable of rendering the cells of cancer harmless. Permit the further remark, that had Dr. Blumenthal carried out the like researches upon normal trophoblast of the early periods of gestation, or on the cells of chorio-epithelioma (trophoblast run riot), he would have obtained the "cancer-ferment" and all the other results which the remarkable investigations of himself and his colleagues yielded upon the cells of malignant tumours.

I am, Sir, yours truly,

J. BEARD.

8 Barnnton Terrace, Edinburgh.

April 5th, 1905.

[The translation referred to by our correspondent will be found on page 375.—Ed]

Obituary.

ALEC LESLIE MATTHEWS, M.R.C.S., I.R.C.P. LOND.

WE greatly regret to record the premature death in Suffolk from pneumonia of Mr. A. L. Matthews. The deceased gentleman held the appointment of Professor of Anatomy at the London Hospital, where he studied, and whence he qualified only so recently as 1900.

JAMES PAYNE BAKER, L.R.C.P. & S. EDIN.

NEW ZEALAND has lost one of her ablest medical men in the person of Mr. James Payne Baker, of Tauranga, Auckland. Originally a student at Edinburgh, he became L.R.C.P. and S. in 1876, and a Fellow of the College of Surgeons of Edinburgh in 1879. After working for a short time in England he went to New Zealand, and there gained a prominent position as a medical man. He took a great interest in Church matters, and often conducted services in places rarely visited by regular clergymen. He was a member of the New Zealand Branch of the British Medical Association, and a Mason of standing in the craft.

JAMES ALEXANDER, M.D., M.B., M.Ch. DUB.,
OF PAIGNTON.

WE regret to record the death, on April 2nd, of Dr. James Alexander, of Paignton, President of the South-Western Branch of the British Medical Association. Deceased was medically educated in Dublin, where he graduated M.B. in 1869. Locally he held various appointments, and had an extensive practice. His death will be felt sorely by an unusually wide circle of friends.

Another Medical Exhibition.

The success of the late Chemists' Exhibition in London appears to have been so pronounced as to lead the promoters of that undertaking to make similar arrangements for a medical and surgical exhibition to be held also in London in the early autumn. It may be contended by members of the British Medical Association that in view of the fact that an exhibition of this nature is a permanent feature in connection with the annual meetings of the Association, another directly after is unnecessary and superfluous. The proprietors of the *Colonial Chemist and Druggist*, who are the promoters of the scheme, think otherwise; they look on the Metropolis as the centre of the empire, and consider that only a small section of the medical profession attend the annual meetings referred to. They therefore hold "that a Medical Exhibition in London, run on strict professional lines, where the best known houses can interview medical men under the most favourable conditions, will be a great business success. Everything will be of a high-class description. The public will be practically excluded by making the admission 5s., but every medical man and dentist throughout the country will receive a special invitation, and a magnificent reception room and club will be reserved for their use. *Nous verrons.*

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 31st ult., at 249 Strand, London, W.C. Dr. de Havilland Hall was in the chair, and there were also present Mr. F. S. Edwards, Dr. Walter Smith, Dr. Frederick S. Palmer, Mr. H. P. Symonds (Oxford), Mr. Fredk. Wallace, Dr. J. Brindley James, Dr. F. J. Allan, and Dr. J. B. Ball. The time of the committee was mostly occupied in examining the list of current sickness claims. As the number of members and their average age have increased the sickness claims account has, of course, expanded, but with the exception of two years in which the influenza epidemic caused an abnormal increase the growth has been quite steady. The financial strength of the Society has grown in a still greater degree, and the accumulated reserves, now amounting to about £200,000, show that the founders of the Society took all necessary precautions to ensure success. Prospects and all particulars on application to Mr. F. Addiscott, Sec., Medical Sickness and Accident Society, 33 Chancery Lane, London, W.C.

Royal College of Surgeons in Ireland.—Election of Examiners.

A MEETING of the Fellows will be held on Tuesday, May 2nd, at 4.30 p.m., pursuant to the provisions of the Supplemental Charter, to witness the election of the following Examiners:—Two Examiners in Anatomy, Four Examiners in Surgery, two Examiners in Physiology and Histology, two Examiners in Pathology and Bacteriology, one Examiner in Midwifery and Gynæcology, one Examiner in Biology, two Examiners in Ophthalmology, one Examiner in Sanitary Law and Vital Statistics, one Examiner in Engineering and Architecture, two Examiners in Chemistry and Physics, two Examiners in Dental Surgery and Pathology, two Examiners in Mechanical Dentistry, one Examiner (not being a Fellow or Licentiate of the College) in Languages, one Examiner (not being a Fellow or Licentiate of the College) in Mathematics, Physics, Dictation, and English Essay. Candidates are requested to lodge their applications in writing with the Registrar, at the College, on or before Tuesday, April 25th, at 10 a.m. Graduates of any University which may be from time to time recognised by the College shall be eligible for election as Examiners in the subjects of General Education. All the other Examiners shall be Fellows or Licentiate of the College. Persons engaged in private teaching are not eligible to be Examiners.

University of Aberdeen.

At the graduation ceremony held on April 7th, the following degrees in medicine and surgery were conferred:—

Degree of Doctor of Medicine (M.D.).—Robert Grant, M.B., C.M., of Chatham; Andrew Ross Laing, M.B., C.M., of Aberdeen; Alexander Ledingham, M.A., M.B., Ch.B., of Hamilton.

Degrees of Bachelor of Medicine (M.B.) and Bachelor of Surgery (Ch.B.).—With *Second Class Honours*:

Robert Brown, of Aberdeen. *Ordinary Degrees*: Mary Ronald Bisset, Dumbartonshire; Alexander Brown, Aberdeen; Duncan Coutts, Torry, Aberdeen; Alex. Dawson, Aberdeen; Walter Allen Elwood, Grimsby; Wm. Gordon Gordon, Aberdeen; William Low, M.A., Folla Rule, Rothie-Norman, Aberdeenshire; James Bredalbane Macdiarmid, Edinburgh; James Edward Mennie, Aberdeen; Alexander Mitchell, M.A., Old Rayne, Aberdeenshire; John Proctor, Aberdeen; Wm. Ewen Reid, Inverness; John Sangster, Lower Bodachra, Aberdeenshire; James Archibald Bruce Sim, Banchory; Robert Haig Spittal, Aberdeen; John Maxwell Taylor, M.A., Stonehaven; Lisette Anne Macdonald Wilson, Aberdeen. Francis William Falconer, Aberdeen, passed all the examinations, but will not graduate until he has attained the necessary age. *Diploma in Public Health*: William Anderson, M.B., Ch.B. (Aberd.), Kintore; George Jamieson Pirie, M.B., Ch.B. (Aberd.), Orkney; Alexander Robertson, M.B. Ch.B. (Aberd.), Elgin; Herbert Wm. Black Ruxton, M.F., Ch.B., (Aberd.).

Notices to Correspondents, Short Letters, &c.

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

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 re-forwarding 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.

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.

DR. W. (Birmingham).—In answer to your question about hot air baths, as far as we can learn all other apparatus are simply variations and imitations of his original patent. The therapeutic value of this form of heat seems to be definitely established.

DR. S. (Edin.).—The need for Scotch Diplomats to associate together has already been mentioned in this paper. The Society now established bids fair to upset the general apathy and indifference that prevails in so many matters affecting professional well-being.

INVALID.—The opening of the innumerable "private homes" by nurses and others who have only a superficial knowledge of treatment has undoubtedly wrought a good deal of harm. It is better to get a list of medical men receiving resident patients from the Association that exists for the purpose.

DR. B. (Worcester).—An arrangement was made by the Potters Insurance Co., Ltd., for the periodical examination of men employed in lead processes, the fees paid to the certifying surgeon being on a higher scale than those paid for a similar service with regard to women. The obstacles in the way of prevention of industrial lead-poisoning, arise partly from prejudice of masters, partly of employees and partly from defective legislation and administration.

LEGO-MEDICAL.—Your communication should undoubtedly be sent to Scotland Yard.

VOTES WANTED FOR AN EPSOM COLLEGE CANDIDATE.

Dr Thomas Dutton asks us to call the attention of masonic members of the profession to the case of A. S. Dutton, a boy of eleven years, who is a candidate for a Royal Medical Foundation at Epsom College in May next. The boy's father (E. G. Dutton, M.B.C.S., L.R.A., M.B.Durh., P.M. Dundas Lodge) died after a few days illness of pneumonia at the early of 40, leaving a widow and two children without means. The case is strongly recommended by Sir Geo. Philipson, Sir Geo. Howse, Dr. Galabin, and other members of the profession. Proxies will be thankfully received by the widow, Mrs. Dutton, Balcombe, Sussex.

M.D. (Somerset).—You had better send a full statement to the Secretary of the Medical Defence Union, Trafalgar Square, London, W., but we should advise you to be very sure of your facts, and able to produce trustworthy evidence.

K.R.—Attention was called to the subject in our issue of March 22nd, page 311, in which the same surgeon was concerned. In the one to which you draw attention the objectionable publicity is perhaps best explained by the fact that the patient is an actress, and that advertising in one form or other is the life of the cult. We can quite conceive that the surgeon was unaware of the use of his name.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, APRIL 12th.

DERMATOLOGICAL SOCIETY OF LONDON (11 Chandos Street, Cavendish Square, W.).—5.15 p.m. Demonstration of Cases of Interest
TUBERCULAR SOCIETY (London Institution, Finsbury Circus, E.C.).—8.30 p.m. Clinical Evening.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. T. P. Legg : Clinique. (Surgical.) 5.15 p.m. Mr. H. L. Barnard : Gastric Surgery.

CENTRAL LONDON THROAT AND EAR HOSPITAL (Gray's Inn Road, W.C.).—5 p.m. Demonstration : Dr. W. Wingrave : Ear.

THURSDAY, APRIL 13th.

BRITISH GYNECOLOGICAL SOCIETY (20 Hanover Square, W.).—8 p.m. Paper:—Prof. Jacobs (Brussels) : Cancer of the Uterus : Surgical Treatment : E suite. (Table Exhibition of the Various Forms of Cancer of the Uterus.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson : Clinique. (Surgical.) 5.15 p.m. Dr. C. O. Hawthorne : The Visual Fields in Health and Disease.

FRIDAY, APRIL 14th.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN (11 Chandos Street, W.).—5.30 p.m. Paper will be read by Dr. C. W. Chapman, Mr. R. C. Dutt, Mr. E. A. Whitelocks, Mr. C. Batchelor, and Dr. Edmund Cantley.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8.30 p.m. Papers: Prof. H. Marsh: (1) A Joint Affection possibly due to Malaria; (2) Cases of Intermittent Hydrops of Joints. Mr. F. J. Steward: Two Cases of Hydronephrosis due to Movable Kidney.—Mr. M. Robson: A Biliary Pulmonary Fistula cured by Hepatocholeotomy.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. L. Paton : Clinique. (Eye.)

Vacancies.

County Asylum, Chester.—Third Assistant Medical Officer. Salary £160 per annum, with board, lodging and washing. Applications immediately to Dr. Lawrence, County Asylum, Chester.
Birkenhead Union.—Resident Assistant Medical Officer. Salary £120 per annum, with board, washing, and apartments. Applications John Carter, Clerk to the Guardians, Clerk's Office, Poor Law Offices, Birkenhead.
Christchurch Union.—Medical Officer. Salary £150 per annum. Applications to A. Druitt, Christchurch.
Christchurch Union.—Medical Officer of District No. 1 of the Union. Salary £120 per annum. Applications to A. Druitt, Christchurch.
West Riding Asylum, Wakefield.—Junior Assistant Medical Officer. Salary £140 per annum, with apartments, board, washing, and attendance. Applications to the Medical Director of the Asylum.
Assistant Medical Officer for County Asylum.—Salary £150 per annum. Applications to the Scholastic, Clerical, and Medical Assn., Ltd., 22 Craven Street, Trafalgar Square, London, W.C.
Birmingham City Asylum, Rubery Hill.—Junior Assistant Medical Officer. Salary £150 per annum, with board, lodging, and washing. Applications to the Medical Superintendent, Rubery Hill Asylum near Birmingham.
National Hospital for the Relief and Cure of the Paralyzed and Epileptic, Queen Square, Bloomsbury.—Resident Medical Officer. Salary £100 per annum, with board and residence. Applications to Godfrey H. Hamilton, Secretary.
Devon County Asylum, Exminster.—Junior Assistant Medical Officer. Salary £125 per annum, with board, residence, and laundry. Applications to the Medical Superintendent.
Sunderland Borough Asylum, Ryhope.—Assistant Medical Officer. Salary £120 per annum. Applications to the Medical Superintendent, The Asylum, Ryhope, Sunderland.
Southwark Union, London.—Assistant Medical Superintendent of their Infirmary, East Dulwich Grove, S.E. Salary £150 per annum, with furnished apartments, board, and washing. Applications to Howard C. Jones, Clerk, Union Offices, John Street West, Blackfriars, S.E.

Appointments.

HOLMES, GORDON N., M.D. Dub., Director of Neuro-pathological Research, National Hospital for the Paralyzed and Epileptic.
MILLS, J. A., B.A., M.B., B.Ch. B.A.O., E.U.I., Assistant Medical Officer and Pathologist to the Durham County Asylum.
PARKER, HERBERT F., M.D. Cantab., M.R.C.S., L.R.C.P., Honorary Assistant Medical Officer to the Royal Surrey County Hospital, Guildford.
PATNE, JAMES BOLAND, M.B.C.S. Eng., L.R.C.P., L.M. Edin., Medical Officer of Health for the Coleford (Gloucestershire) Urban District Council.
PRICE, ERNEST H., L.N.A., Assistant House Surgeon to the Northampton General Hospital.
WATKINS, ERNEST M., M.B., C.M. Glasg., House Surgeon of Wrexham Infirmary.

Births.

SWORDER.—On April 6th, at Aldenham 2, Clifton Road, Folkstone, the wife of Dr. Ernest Sworder of a daughter.

Marriages.

OWEN - HOLLAND-THOMAS.—On April 4th, at Montreux, Switzerland Sir Isambard Owen, M.A., M.D., Principal of Armstrong College Newcastle-on-Tyne, and Senior Deputy Chancellor of the University of Wales, to Ethel, third daughter of the late Lewis Holland-Thomas, of Caerfynnon, Merionethshire.
WALLACE - CLOUSTON.—On April 6th, at St. Giles's Cathedral, Edinburgh, David Wallace, C.M.G., F.R.C.S.E., 11 Rutland Street, Edinburgh, to Augusta Maud, only daughter of T. S. Couliston, M.D., Tipperlinn House, Edinburgh.

Deaths.

CADELL.—On March 4th, at Sydney, New South Wales, Christian, fourth daughter of the late James John Cadell, M.D., aged fifty-three years.
MACFADEN.—On April 7th, at 38 Rockmount Road, Upper Norwood, Mary Elizabeth, daughter of the late James Macfadyen, Esq., M.D., F.R.S., etc., of Kingston, Jamaica, aged 55.

MEDICAL OFFICER WANTED for High-Class Sanatorium; unmarried; with capital; must take half share interest with owner.—Particulars, C., 43, Howard Street, Derby.

MEDICAL MAN WANTED (single preferred) to take charge of two or three private patients and work up a new practice in partnership with advertiser.—C., 43, Howard Street, Derby.

The Medical Press and Circular.

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Original Communications.

THE MECHANISM OF ASTHMA.

By FRANCIS HARE, M.D.,

Late Consulting Physician to the Brisbane General Hospital; Visiting Physician to the Diamantina Hospital for Chronic Diseases, Brisbane; Inspector-General of Hospitals, Queensland.

THERE can be no doubt that the asthmatic paroxysm depends on a temporary obstruction to respiration, and but little doubt that the site of the obstruction is the smaller bronchi or bronchioles. As to the nature of the obstruction, however, two views are held, namely, (1) that there is a constriction of the tubes by spasm of their own circular muscular fibres; and (2) that there is a rapid swelling of the mucosa of the tubes from fluxionary hyperæmia, angio-neurotic œdema, or vascular distension, dependent on vaso-motor action. The two views seem essentially antagonistic and it is of real importance to decide between them.

The bronchial constriction hypothesis was widely adopted on the discovery of the existence of circular muscular fibres in the bronchial tubes; it is still held, I imagine, by the majority of physicians. A sudden constriction of the smaller tubes would explain the suddenness of the onset and of the subsidence of the asthmatic attack, the auscultatory signs, the strong diaphragmatic contraction, the tendency to fixation of the chest walls in the position of almost full inspiration, and the limitation of the respiratory movements to a narrow margin on either side of this point. Starling says that the asthmatic "type of breathing is often described as being marked by expiratory dyspnoea. This description is, however, erroneous. The muscles, which in these cases are contracted to their utmost, are the inspiratory muscles: the expiratory muscles such as the abdominal, will be found to be quite flaccid during expiration." (1) My own experience is confirmatory. Respiration during the asthmatic paroxysm is maintained by powerful inspiratory efforts alternating with extremely cautious and therefore slow, relaxations of the inspiratory muscles. The patient dare not suddenly relax the inspiratory spasm, still less make any serious use of his expiratory muscles. Moreover, contrary to what obtains in normal respiration, the longer respiratory pause occurs at the end of inspiration because it is then that the tubes are most patent. At the end of expiration there is no pause because then the tubes are least patent, and a sudden resumption of inspiration becomes an urgent necessity. The practical fixation of the chest in the position of full inspiration must be regarded as a conservative device adapted to antagonise the diminution of the bronchial lumina and thus to maintain a passage of communication between the air-cells and the outer atmosphere.

Now it is obvious that, though all the above observations are consistent with bronchial constriction, yet none are inconsistent with vascular distension; they all constitute, in fact, merely evidence of rapid obstruction of the tubes, and do not serve to elucidate in any

way the mechanism of that obstruction. It has been argued, indeed, that the suddenness of onset and subsidence of the asthmatic dyspnoea is strong evidence in favour of bronchial constriction; but those who have watched a case of acute urticaria or angio-neurotic œdema will be able to realise that the onset of vascular distension is often sufficiently rapid to account for the onset of asthma, and the subsidence of vascular distension for the subsidence of asthma. But there is circumstantial evidence that in many cases the onset of the bronchial obstruction in asthma is less abrupt than is commonly supposed. It has been observed that general enlargement of the chest, with descent of the diaphragm, precedes the onset of dyspnoea. Several ladies have informed me that the earliest warning they experience of an impending paroxysm in the daytime is an increasing tightness of the corset. If this garment can be loosened, the attack is deferred for a time; otherwise, it quickly attains its climax. Now this pre-dyspnoeal progressively increasing expansion of the chest is entirely consistent with a progressively increasing swelling of the bronchial mucosa, but less so with muscular spasm.

Perhaps the clearest illustration of the capacity of vascular distension, to account fully for the phenomena of the most explosive asthmatic paroxysm, consists in the rapidity with which the nasal passages may become completely blocked by nervous erethism of their mucous membrane in many circumstances. Brodie and Dixon, however, consider it "unsafe to argue that because the nasal mucous membrane can rapidly become turgid and swollen and as rapidly recover, a similar thing can occur in the bronchi." (2) They point out that "the nasal mucous membrane, especially over the inferior turbinate bone and lower nasal passages, is extremely vascular, and in many parts large venous plexuses are found encircled by bundles of muscular fibres, thus forming a sort of cavernous erectile tissue (Klein)"; (2) but that "the bronchial mucous membrane, on the other hand, is thin and possesses what is, in comparison, a relatively insignificant blood-supply." (4) The anatomical differences between the two mucosæ may be freely admitted; and the limited capacity for erection of the latter must be regarded as fortunate. For were the mucosa of the bronchioles liable to become turgid in degree proportionate to the nasal mucosa, then many, if not most, asthmatic paroxysms would probably prove rapidly fatal.

It may be admitted that so far the investigation is inconclusive; all the observations hitherto adduced are explicable, though not perhaps with equal satisfaction, either on the bronchial constriction or on the vascular distension hypothesis. But there is a further long series of observations which lend no support to the former, but which are all readily explicable on a *comprehensive vaso-motor hypothesis*. It will be convenient in the first place to enunciate this vaso-motor hypothesis and thereafter to collate the clinical observations which support it, and which it may be taken to explain.

Leonard Hill says:—"The maintenance of a mean arterial pressure of constant height is the object of

the circulatory mechanism. On the one hand, we are convinced that this object is attained during life; on the other hand, we know that countless and ceaseless variations are occurring in all parts of the circulatory system. The system must therefore be so craftily built and so delicately balanced, that every variation in one part is compensated by a simultaneous and contrary variation in another part, and thus, throughout the wear and tear of life, the aortic pressure is kept at a constant mean height." (5) The principle of compensation by an area of vaso-dilation for an area of vaso-constriction is thus fully recognised in physiology, but seems to have been rarely adduced in the elucidation of pathological problems. Nevertheless, this principle will be found to go far towards elucidating the meaning and mechanism of numerous morbid affections which at present remain obscure; it will, at least, be applicable to the mechanism of the asthmatic paroxysm. It is obvious that there could be no more effectual means of promoting vascular distension in any given site than a widespread vaso-constriction combined with a vaso-dilation localised at the site in question. Nor will it be difficult to show with some approach to certainty that such a combination occurs in asthma. During the paroxysm there is widespread vaso-constriction affecting in most cases the cutaneous area, especially that of the extremities. This tends to be compensated by an internal vaso-dilation which affects, but is probably not always limited to, the bronchial area. Thus vascular distension and swelling of the bronchial mucosa arises; and this, affecting the smaller tubes, is responsible for the obstructive dyspnoea.

The cutaneous vaso-constriction is conspicuous, the pallor and sense of coldness, subjective and objective, of the skin, especially of the extremities, has been noted by most authorities. Hyde Salter says:—"The pulse during severe asthma is always small, and small in proportion to the intensity of the dyspnoea; it is so feeble sometimes that it can hardly be felt. . . . I have never known the small pulse absent in severe asthma." (6) William Russell refers to the case of a man, *æt.* 53, the subject of "spasmodic" asthma:—"It was quite clear that when the asthmatic spasm supervened, his radial arteries became markedly tightened up. During the paroxysm the arteriometer measurement of the radial was 2.2 mm.; after the paroxysm was relieved by liquor trinitrini the diameter of the radial rose to 2.4 mm." (7) That the constriction of the radial is intimately bound up with the paroxysm, is shown by the fact that "immediately the paroxysm yields, the pulse resumes its normal volume" (Hyde Salter). (8) Many of the premonitory and initial symptoms of the attack may depend upon the vaso-constriction. The premonitory drowsiness may depend upon a degree of cerebral vaso-constriction and anæmia; the paræsthesiæ which Romberg termed "asthmatic auræ," may be referred to vaso-constriction localised in some cerebral centre or at the periphery; and the diuresis, which, according to Hyde Salter, may occur so early in the attack that the patient is awakened from his sleep by the distension of his bladder when the dyspnoea is but just commencing, is fully explicable by widespread cutaneous vaso-constriction, or by any sufficiently extensive and inadequately compensated vaso-constriction in which the renal arteries do not share.

The compensatory internal vaso-dilation is in part also conspicuous. During the paroxysm in many cases the nostrils are blocked by vascular distension of their erectile mucosæ; and "Störck actually observed with the laryngeal mirror that in certain instances of asthma the whole length of the trachea and part of the right bronchus were deeply congested" (Goodhart). (9) The vaso-dilation of the smaller tubes which is responsible for the dyspnoea is, of course, invisible during life. Recently, however, a *post-mortem* examination was made by Fraenkel on a case that had died during a paroxysm, and the morbid appearances were consistent with what might have resulted from vaso-dilation. Microscopically marked

changes were found in the smallest bronchi or bronchioles—i.e., tubes which still retain their stratified columnar epithelium, but which have lost their cartilages and glands, and which are about to break up into the alveolar passages and infundibula; and the changes were confined to tubes of this size. (10) But the vaso-dilation, though invisible during life, is fairly inferable from the above observations, from the close association between asthma and urticaria, an affection obviously dependent on vaso-dilation, and from numerous other clinical observations. Hyde Salter points out that "hæmoptysis, not by any means a common event in asthma," may occur "as an accompaniment of the asthmatic paroxysms, and in quantity proportionate to the intensity of the dyspnoea." (11) Hæmoptysis might easily result from vascular distension, but hardly from bronchial constriction. Further, there can be no more rapid means of relief from vascular distension than profuse hæmorrhage from the distended area; hence hæmoptysis to any extent invariably terminates immediately the asthmatic paroxysm—at least, this has been so in my experience.

The action of practically all the therapeutic methods which have been, or may be, employed for the relief of the asthmatic dyspnoea, may be explained on the above vaso-motor hypothesis; the great majority can be explained upon no other, so far as I am able to see. The vascular distension of the mucosa of the bronchioles assumed to be responsible for the obstructive dyspnoea, might be reduced (1) by vaso-constriction in the dilated area, (2) by vaso-dilation in the peripheral constricted area, (3) by reduction in the force of the heart-beat, and (4) by reduction in the amount of blood in the circulation. Conformably it will be found that therapeutic measures which act in any one or more of these ways, are capable of relieving, if not dispersing, the asthmatic paroxysm.

Vaso-constriction in the Dilated Area.—Cold locally applied is an efficient vaso-constrictor. In asthma, cold may be applied to the dilated area through inhalation from an apparatus containing broken ice. The salutary influence upon the dyspnoea is always marked, but ceases with the inhalation. Demarquay pointed out "that paroxysms of asthma subside in certain individuals under the influence of keen air." (12) In others the opposite may occur; in such it is probable that the general surface is inadequately protected and that the exacerbation is due to an exaggeration of the cutaneous vaso-constriction.

Adrenalin is probably the most powerful of all local vaso-constrictors; and several recent writers (N. W. Jipson (13) of the Lakeside Hospital, Chicago, and F. J. Savage, of Bowersville, Ohio) have procured immediate relief from the asthmatic paroxysm through inhalations of adrenalin chloride solutions, varying in strength from 1 in 10,000 to 1 in 1,000. But this drug is also a powerful general vaso-constrictor. Consistently, Drs. Jesse G. M. Bullowa and David M. Kaplin (14) have published a series of five cases in each of which adrenalin chloride, hypodermically administered, gave rapid and complete relief from the asthmatic paroxysm. In these cases the exaggerated general vaso-constriction would be powerless to increase the bronchial vaso-dilation since the bronchial area also would be actively constricted; the general increase of peripheral resistance would be compensated by some vagus inhibition of the heart-beat.

Probably the relief afforded by many fumes is attained through direct vaso-constriction in the dilated area. For not only the smoke of "anti-spasmodic" herbs such as stramonium, but also that of burning nitre paper, which is nothing if not irritating, affords striking relief in asthma. The action of such remedies upon the swollen mucosa in asthma seems similar to the action of a pinch of snuff upon the swollen nasal mucosa in ordinary catarrh. The action of astringent solutions in gonorrhœa, conjunctivitis, &c., is parallel.

There is little doubt that the relief which follows inhalation of chloroform is attained in some cases through direct vaso-constriction in the dilated area. Chloroform vapour sometimes causes visible anæmia

of the congested nasal mucosa. And Hyde Salter says of a case of asthma:—"The first act of inspiration was accompanied with a sensible relief long before the blood charged with chloroform could have reached the nervous centres." (15)

The above argument receives important support from the fact that many conditions capable of increasing bronchial vaso-dilation are capable of exaggerating the asthmatic paroxysm. Patients suffering from mild asthmatic dyspnoea often become conspicuously worse on entering a hot room. And I have once, but only once, tried the effect of warm inhalation during a severe asthmatic paroxysm; I do not suggest a repetition of the experiment.

Vaso-dilation in the Peripheral Constricted Area.—Many remedies seem to act essentially through this means. Amyl nitrite and nitro-glycerine are well-known to dilate the periphery; and both have been used with success in asthma (Lauder Brunton.) (16) It has been suggested that these drugs operate by relaxing the bronchial spasm; but there is no evidence that the nitrites in medicinal doses have any paralysing action on muscular tissue (17) other than that of the middle arterial tunics.

Alcohol, opium and morphia cause cutaneous vaso-dilation; and all have been found capable of giving immediate relief from the asthmatic paroxysm (Hyde Salter).

Heat is probably the most efficient vaso-dilator of the cutaneous area; and I have never known a hot bath (water, vapour, air) fail to give some immediate relief from the dyspnoea of asthma. Graves found it "serviceable to stupe the whole chest during the fit with flannel wrung out of water as hot as could be borne." (18)

The most efficient thermal means of relieving the asthmatic paroxysm is the application of heat to the whole surface, as by a vapour bath, combined with the simultaneous inhalation of ice cold air. This combination has never failed in my hands. Its rationale is obvious on the vaso-motor theory, not, I think, on any other.

If conditions which relax the peripheral vaso-constriction relieve the asthmatic paroxysm, then it follows that conditions which exaggerate the peripheral vaso-constriction will have a precipitating or accentuating influence. The invasion stage of most fevers associated as it is with conspicuous vaso-constriction of the skin, is liable to precipitate an asthmatic attack in those who are predisposed thereto. I have known this occur in ordinary febrile catarrh, in influenza, ague, and dengue. Cold to the surface acts similarly. Hyde Salter says:—"I am acquainted with the case of an asthmatic lady whom a walk of two minutes in her garden will render asthmatic, if her chest is bare. This is evidently not from the respiration of cold air, for under identical circumstances the mere fact of her chest being covered will entirely prevent the occurrence of asthmatic breathing; the same result as immediately follows if her feet get damp and cold." (19) Similar observations may be made every day.

The two-fold influence of thermal conditions upon the vascular balance of the bronchial mucosæ is hopelessly confusing to the asthmatic who has but a half knowledge of the mechanism of this influence. Recognising the prejudicial effect of cold air in precipitating paroxysms, he is apt to shut himself up in a stuffy room, thus inviting the vaso-dilative influence of warm air on the bronchial mucosa. Recognising the prejudicial influence of warm air during the paroxysm, he is apt to rush to an open window and expose more or less of the surface of his body, thus inviting the vaso-constrictive influence of cold air on the peripheral cutaneous area. He is, of course, wrong in both cases. The only rational thermal management, both in the interval and during the paroxysm, consists in keeping thoroughly warm the skin of the whole of the body while breathing cool air. Explanation and directions to this effect have greatly increased the comfort of many asthmatics.

The influence of emotion upon the vascular state of

the skin varies widely with the emotion and with the individual. For which reason, probably, emotion produces effects upon the asthmatic which are seemingly contradictory. Hyde Salter says:—"Psychical stimuli—excitement, fear, or other violent emotion—are adequate to the immediate production of the asthmatic spasm"; (20) but, again: "The cure of asthma by violent emotion is more sudden and complete than by any other remedy whatever; indeed, I know few things more striking and curious in the whole range of therapeutics". (21) Salter thinks emotion acts by causing a "diversion of nervous energy"; but, I submit, a diversion of vascular pressure offers a more tangible explanation of the facts.

Vaso-dilation in areas other than the skin will be equally effectual. Shock from any cause is probably always associated with splanchnic vaso-dilation (Crile); and shock is well known to be capable of dispersing the asthmatic paroxysm.

Reduction in the Force of the Heart-beat.—This, however induced, would directly reduce vascular distension in any area. Conformably many remedies which given in adequate doses cause weakening of cardiac action can be shown to relieve the asthmatic paroxysm. Of tartar emetic and tobacco, Hyde Salter says:—"As soon as their characteristic effect is established, the dyspnoea ceases—completely ceases from that moment; no matter how intense the spasm may have been, the moment the sensations characteristic of collapse are felt, it yields, the respiration is free, and the patient passes from agony to ease. It is one of the most striking things to witness in the way of an effect of a remedy that can be imagined. (22) He shows that in habitual smokers and in those who are unfortunate enough to have established a tolerance of tobacco, its beneficial influence is lost: "just in proportion to the sickness and faintness and other miserable sensations, is the relief of the difficult breathing." (23) Lobelia also, as Salter points out, must be given in doses sufficient to produce "the characteristic depressant action of the drug." (24)

On the other hand, influences such as sudden exertion and that of ammonia, which increase cardiac action, may increase or precipitate asthmatic dyspnoea.

Reduction in the Amount of Blood in the Circulation.—This obviously will reduce vascular distension in any area. Conformably we have noted the influence of hæmoptysis. But bleeding from any area will act similarly. Trousseau refers to a case in which violent asthma was prevented from ending fatally only by bleeding. (25) Venesection never fails to relieve asthmatic dyspnoea for the time being. And cases in which recurrent asthma alternates with recurrent epistaxis or hæmorrhoidal or other hæmorrhages are freely recorded in medical literature.

The evidence adduced goes to show that the asthmatic paroxysm depends upon a special pathological variation of vaso-motor action. Of such pathological variations there are numerous examples. Direct and circumstantial evidence can be adduced to show that the phenomena of the paroxysms of migraine, angina pectoris (the so-called functional form), some cases of epilepsy, some gastralgias and neuralgias, Raynaud's disease, recurrent temporary amblyopia, erythromelalgia and urticaria, are essentially of vaso-motor mechanism. It is reasonable to ask, then, of what nature are the causes of the pathological variation of vaso-motor action? Recently a tendency has arisen to refer many of the affections enumerated to *humoral* causes, to morbid conditions of the blood, or toxæmia; and it has been suggested that the differences in manifestations may depend upon differences in the nature of the toxæmia. But, as I shall point out elsewhere, there is at least one humoral factor, namely, the malarial poison, which is certainly responsible for some cases of all the above-named affections. And I shall argue further on a future occasion that there exists a still more common humoral factor which is fundamentally responsible for many of the non-malarial paroxysmal neuroses (including asthma),

and that the differences between these affections depend upon secondary or determining functional factors, which may be personal (hereditary, congenital, or acquired) or due to environment.

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- (3) *Ibid.* p. 12. (4) *Ibid.*
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- (12) "Oxygen and Other Gases in Medicine and Surgery." Demarquay, Wallian. Pub. F. A. Davis. 1899. P. 130.
- (13) "Kansas City Medical Index," *Lancet*, Sept., 1902.
- (14) *New York Medical News*, Oct. 24th, 1903.
- (15) "On Asthma." 1868. P. 217.
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- (18) "Clinical Medicine." New Syd. Soc., Vol. II., p. 99.
- (19) "On Asthma." 1868. P. 312.
- (20) *Ibid.*, p. 147. (21) *Ibid.*, p. 210. (22) *Ibid.* p. 184. (23) *Ibid.*, p. 187. (24) *Ibid.*, p. 240.
- (25) "Clinical Medicine." New Syd. Soc., Vol. I., p. 643.

PHTHISIS:

ITS CORRELATIONS AND CONTINUITY.

By WILLIAM H. PEARSE, M.D.ED.,
Consulting Physician, Plymouth Public Dispensary.

I HAVE often been able, by the courtesy of THE MEDICAL PRESS AND CIRCULAR, to depict the prevailing types of variation, both of structure and function, which correlate with the future phthisis. (a)

It is not my intention again to go over this ground. I may remark, however, that in biology and pathology we are apt to take far too limited a view of the Time involved in changes, variation, and disease; in truth, the correlations and continuity of an almost infinite time are involved in the functions of a cell, and of all structures and functions. We now, as *à priori* truths, allow an almost infinite time in geological changes, in the evolution of languages and mythologies, but do not carry this spirit of method into pathology; on the contrary, we are ever prone to rest in the catastrophic method of single and immediate "causes" of disease.

It appears to me, that the medical mind will never rise to a just view of the fields of medicine, until the old catastrophic philosophy of Europe is swept away, and in its place has arisen an *à priori* Idea of orderly Evolution and Continuity.

I propose to depict a few selected cases of phthisis to show the wide correlations and continuity of phthisis in its wider Form or Nature. But before I attempt this little task, I beg to quote the words of Bacon, in order to show that I am not unmindful of the dangers to truth, which beset "affirmative instances." Bacon says:—"For the mind of man is far from the nature of a clear and equal glass, wherein the beams of things should reflect according to their true incidence; nay, it is rather like an enchanted glass, full of superstition and imposture, if it be not delivered and reduced . . . as first, in that instance which is the root of all superstition, namely, that to the nature of the mind of all

men it is consonant for the affirmative or active to effect more than the negative or privative. So that a few times hitting, or presence, countervails oft-times failing, or absence, as was well answered by Diagoras to him that showed him, in Neptune's Temple, the great number of pictures of such as had escaped shipwreck, and had paid their vows to Neptune, saying: 'Advise now, you that think it folly to invoke Neptune in a tempest.' 'Yea,' but saith Diagoras, 'where are they painted that are drowned?'"

With this great philosophy of Bacon vividly before my mind, I not the less think that some "affirmative instances," illustrating the constitutional, general, and wide biological correlations and continuity of phthisis, may be of value, and light-giving; but ever remembering that they represent but a part of an almost infinite biological field.

To be of real value, I must give the outline, as the patients described their cases.

F. M., æt. 19, came to me in March, 1882. He said:—"I was jolly well up to three months ago; then the voice went and I got cough; I sweat toward morning; feel a chill at times; it runs right over me. I can eat anything, sweet or sour; not onions; like pickled onions; like oranges; not salt meat or salt fish; like butter, but no other fat; never could eat any fat." Upper teeth not gone; tongue large for space of palate. Eyebrows heavy and meet in central line. Nose high and mesial. Hands large and always cold; nails large and rounded. His mother and one young adult sister died of phthisis.

I found the right infra-clavicular region a little dull on percussion to the fourth rib, and small moist râles at end of inspiratory sound; had spat blood. The left side was natural. I prescribed acid muriat, dil., quinine, and arsenic; also cod-liver oil. He died of phthisis in three months.

H. M., æt. 17, brother of the above, came on March 25th, 1882. He had no cough, nor physical signs in the lungs, nor hæmoptysis; he was wasting, costive, and suffered "indigestion"; could eat fats; liked onions, pickles, very fond of a leek; "can eat anything!" Nose unduly oblique to right, eyebrows heavy, and meet in mesial line; lower maxilla rather tends to left; nails squat. I prescribed quinine and muriatic acid; also cod-liver oil. He returned in October, 1883; had had hæmoptysis; skin hot, pale. He died of phthisis at end of 1883.

C. M., æt. 23, brother of the above two, came in March, 1883. His appearance was remarkable. My notes of his case state: "The eyebrows heavy and meet in a full wide interlock, and bunch at root of nose. Nose markedly to left; terminal cartilages large and unsymmetrical; sulcus at apex of nose very marked. Nails large; hands cold; pale; feet cold at night. Has no indigestion, can eat fats, likes pickles, but not particularly fond of onions."

I found the right clavicular region dull on percussion; the right infra-clavicular region had fair resonance on percussion, with rather blowing inspiratory and expiratory sounds, and having a dry type of crepitation. The left infra-clavicular region had good resonance on percussion; a little wheezing in both dorsal regions.

In other words, the man had a very small area of phthisis at the right apex. He came on March 3rd, and died the ensuing April—a case of rapid phthisis.

Besides these three young men, another younger brother, whom I did not see, æt. 17, died of rapid phthisis the year following.

Thus, in this family, the mother, daughter, and four sons died of phthisis.

We may fairly seek to interpret the facts of the above family history, to trace the sublime order and continuity of the biological and pathological "Laws," or, to use the far better word of Plato and Bacon, the "Form" of the phenomena.

Our method in such a study must be the comparative, that which has revealed Ideas and Light in all other fields of knowledge; and that comparative Method must work with the *à priori* and "necessary truth of" cosmic evolution and continuity throughout all Nature.

(a) THE MEDICAL PRESS AND CIRCULAR, May 14th, 21st, 28th, June 4th, 11th, 18th, 1884; February 13th, 20th, September 4th, 1901.

Heredity.—In this M. family, where the mother and daughter and four sons died of phthisis, we see heredity in the mother's lines of the organic evolution. It is not meant that phthisis is a definite disease, or approximate entity, which is hereditary, but that the infinite, nay, cosmic correlations of the energies or motions which make for the organic cell failed in the ovum cell of the mother, and that such failure found its natural, orderly, and, it may be inevitable, sequence in the early failure of vital attractions or modes in the lung-apex bioplasm of some of her children, i.e., of the continuity of her being, in the spiral evolution of the body, and most markedly in one lung-apex. We must learn to view heredity as cosmic in its base and correlations, and as involving an almost infinite Time, and a no less infinite delicacy, yet power, of the variations of the energies and motions which make for life.

There was a marked general likeness in the three brothers, in peculiarities both of structure and function, but the deviations of structure and function were not absolutely the same in the three cases; one may fairly compare such minor differences to a kaleidoscopic view—variations of the same objects within a limited area, e.g.:—

F. M., æt. 19, with slight physical signs, had morning sweats, chills, never could eat any fat. Nose high and mesial; nails large and rounded. H. M., æt. 17, without physical signs, was wasting, costive, and suffered indigestion; could eat fats, liked onions and a leek; "can eat anything"; nails squat. C. M., æt. 23, had no indigestion, could eat fats; liked pickles, but not particularly fond of onions. In structural aspects, the eyebrows were vast, the terminal cartilages of nose vast and unsymmetrical, with sulcus at tip of nose; nails large; hands cold; feet cold at night.

Such are the minor variations of the greater general resemblances. It will be seen that all the layers of the blastoderm, in their future differentiations, were involved. The skin, skeletal, and great digestive organic tract in its glands, were all, in varying degrees, involved in the three cases.

In short, beautiful as are the researches of the minute anatomist and physiologist on the blastoderm and its layers, yet in the functions of a living organism they all blend and form one harmonic unity; the unfolding of this great unity is beautifully seen in the varying types of præ-phthisis and phthisis, both in relation to structure and function.

The vital formative energies, of which we know but little, of its ions, radio-activity, &c., of the remotely differentiated bioplasm of lung apices, like those of the skin at the vertex, or of the temporal region, cease to exist in their full motions and attractions; then the unicelled bacillus finds nidus for his non-differentiated, non-diffused, and stronger attractions.

But in different cases the vital energies and attractions of lung-apex bioplasm cease their powers in very different periods, varying from months to many years; these variations—of the duration of phthisical cases—are strictly determinate and correlative to the general functions and structures, and even to a heredity probably of long-generations and vast periods of time.

Nor, in the vast and intimate involvements and correlations of the whole organism can one exclude the beautiful, sweet, resigned spirit and hope of the præ-phthisical and phthisical, from being a true part of the full Form of phthisis; the very highest differentiations of the nerve and brain systems are even primarily involved—whose after concrete forms are the partial death of lung-apex bioplasm, and then the actions of unicelled organisms.

Are we not too prone to measure disease by one "cause," by one visibly structural change?

But as our functions and duties are not only to discover the "true Forms" of disease, to carry into pathology the higher Method which has had re-birth in Europe with Kant and Goethe, and which has influenced so greatly the method of physics, chemistry, philology, mythology, &c., but as we also have to seek

to prevent disease, it becomes of supreme importance that we make our practice consonant and harmonic with the wide, orderly, slow, yet all powerful, order of the evolution and correlations of the organic.

We have to deal with an outer and an inner environment. And especially as to outer environment, I cannot avoid contrasting the facts of India and Britain. The races are the same. The young native of India, in comparison with him of Britain, is practically free from phthisis. How? In a practical point of view, he lives an out-of-door life; up to nine to ten years of age he is naked; throughout the entire lives of men and women, such is the perfection of their dress, that no muscle or limb is cramped, or organs cramped in their action. But I will refer only to the thorax. Every native, from earliest childhood, has the fullest and freest expansion of the thorax. The arms swing naturally and gracefully in children, men, and women; the thorax and especially the upper segments are ever being expanded. The lungs are thus fully used and *à fortiori* fully nourished; there is thus but little phthisis, though bronchitis is extremely common in the colder months.

Contrast this beauty and elegance with the cramping dress of the European, and especially with the sheer floss of woman's dress and fashions—the thorax "cramped, cabined, and confined." "East is East, and West is West," and Parliamentary language fails to describe European follies. But European mothers might have the mercy on their beautiful girl children to give the thorax free play, to give the means for habitual deep breathing, and free from the corset.

I instruct children to open their bedroom windows on rising, shut the lips, and then draw in several long breaths; at the same time, to do some "extension motions"—without dumb-bells—with the arms; thus the upper lung-segments are exercised and nourished. This done every day from early life has a great effect for good. I advise that children shall have a ten minutes' gentle run out of doors at once after rising.

Mothers might also give that exquisite series of structures, the ankle, freedom and play by the use of sandals or low-heeled, square-toed shoes.

The free use of the ankle-joints is of supreme importance toward the free use of the muscles of the entire body; a free springy foot and ankle gives "life" to the movements of the whole system.

The prevention of phthisis must be by slow, orderly, constant, and gentle means—means in harmony with the order of growth or evolution—no violent single parts.

Food.—Taking a historic view, one cannot avoid asking how far the food of the native of India may conserve him from phthisis. He takes the entire grain of the rice; he avoids the highly cultivated kinds of rice; or if he chiefly uses millet or wheat, the flour holds a good deal of every part of the grain. His Dhall—a lentil or pea—is taken entire; his Gram, also a lentil, is eaten entire; the "curry stuffs" are ground up entire, and hold a large amount of aromatics and essential oils—the benzene molecule. He largely uses the onion—the allyl molecule. He prefers the dark native salt. Acid fruits—the tamarind, lime-juice—are his delight. Some sugar, ghee (butter), cocoa-nut, and vegetables. Water is his sole drink. On such diet, for ages, the race has kept fairly free from phthisis.

I think that we might well take an occasional historic or national view of disease, no less than limiting our view to mere structural pathology. The type of my experience naturally leads me to the contrasts of the East and West; but as I began with an account of the deep-down, and far-back, biological modes of the M. family, so I will conclude by two cases, out of a great number of such, of allied type:—

B. O'B., æt. 17, came April, 1902. The left apex had moderate physical signs of phthisis. She said:—"I've been languid and weak for two or three years; the first thing wrong was that I felt weak and could not get about; tired always; never was strong." She had a very placid, still expression of face; menses

irregular; hands cold; nails almond shape, and very fine in texture; very fond of pork; liked pickled onions. One sister, her father's first cousin, her father's brother, and five of his children died of phthisis. B. O.'B. died two months after, of phthisis.

Bessie H., *æt.* 21, came in November, 1903. She was a country servant; a tall, big-limbed girl, with big and cold hands and feet; feels weak, and not equal to her work; not wasted; menses scant, off two or three months now and then; poor appetite for meat, but likes onions. Her father's four sisters and his two brothers died of phthisis.

I do not think that we can fail to see, in the five cases I have cited, how grandly *general* is the basis of phthisis; I could from a long series of records illustrate the Atavism and Alternation, both of structure and function, of many of the greater præ-phthisical deviations.

I think, too, that to have kept either of these five cases, day and night, with knocked-out windows in the winter, in 50° N.L., would not have been a treatment in harmony with the laws of Nature; give pure air by all means, but warmth and radiant heat are "energy," physical and vital. The sense of weakness and coldness for years prior to the lung disease, is as true a part of the Form of phthisis as is the final bacillus.

My field of observation has taught me, above all else, how *general* a disease is phthisis; how profound is its Continuity, and wide its Correlations.

TWO CASES OF WOUNDS OF THE FEMALE GENITALS.

By R. J. KINKEAD, M.D. DUB.,

Professor of Obstetrics, Queen's College, Galway; Physician and Gynaecologist to the Galway Hospital.

WHEN a woman falls astride on a hard substance, or receives a kick on the genitals, owing to the small amount of tissue between the surface and the bones, the resulting wound is incised rather than lacerated. The vulva being profusely supplied with blood-vessels, and the veins forming the bulbs of the vagina anastomosing freely with those of the vagina, uterus, and rectum, the bleeding from such wounds is profuse, and if the woman be pregnant is appalling; the nearer to term the larger the vessels, and the greater and more rapid the loss of blood. In all cases dangerous, in advanced pregnancy wounds of the genitals are usually fatal. We not infrequently read in the papers a report that a pregnant woman received a kick in the lower part of her body, was immediately conveyed to hospital, and was either found to be dead on arrival, or died in a few minutes after admission.

The two following cases are interesting, one from a forensic as well as from a surgical point of view; the other from the extensive injuries inflicted.

About 7 p.m. one evening in the Spring of 1903, I was stopped on my way home and asked to go at once to a woman who had met with an accident, and was "bleeding to death." Her husband, who gave me the message, said he had rushed off at once, it took me two minutes to ride to the house, so I saw her within ten minutes of her being wounded. She was a married woman, *æt.* 34, the mother of several children, and some months previously had had a bad miscarriage. I found her blanched, pulseless, the heart's sounds almost inaudible, sightless, semi-conscious, respiration sighing. There being no visible wound, a trained maternity nurse, who had gone to her assistance, believed the bleeding to be uterine, and had applied wet cloths to the vulva and lower parts of the abdomen; the bleeding had ceased, but the woman was perilously near death. I gave her a

hypodermic of ether, had hot bottles applied to feet, limbs and body; some ounces of hot normal saline were thrown up the rectum, and ten ounces transfused under the breasts. As she rallied the bleeding recommenced from a wound in the anterior wall. She was too weak and collapsed for operative interference, so I had to be content with plugging and the application of a "T" bandage.

In the morning, April 24th, there having been no further hæmorrhage, she was brought to hospital. I found an apparently incised transverse wound, an inch and a half in length, in the anterior vaginal wall, fully an inch inside orifice, involving the urethra, and which bled freely on removal of plugs. To stop the bleeding, rather than in the hope of obtaining union, I sutured it. Her temperature on admission was 90°, at night 101°. On the 25th there was no bleeding, temperature 100° to 101°, vomiting during night; some oozing on the 26th, which was stopped by adrenal; wound not looking healthy. Vomiting continued on the 29th; right wrist became painful and puffy; edges of wound sloughing; touched with pure carbolic acid.

She went through a severe attack of septicæmia, in addition to the right wrist the right groin and left shoulder were affected, constant vomiting, profuse sweating. On three occasions the temperature went up to 105·8° and 105·6°, but fell immediately on administration of Warburg's tincture. She was discharged on July 27th. The application of carbolic acid stopped sloughing of wound, which, however, was slow in healing. Although the urethra was cut, and for a considerable time urine escaped though the wound, there is now, after the lapse of over a year, no stricture, nor any difficulty in micturition.

Her history of the occurrence was that she had a dispute with her husband, that he gave her a push; she had stumbled and fallen over a Windsor-chair, the legs of which had been cut down for nursing purposes, and that one of the legs had gone up into her. After her recovery, however, she admitted that the injury was produced by a kick, the story of the overturned chair being invented to shield her husband.

It is here that the medico-legal interest of the case comes in, for the appearance was consistent with the chair story, as there was no injury of the vulva, the only external mark being an ecchymosis, which appeared on the second day, half-way between the right labium majus and the thigh, while, *a priori*, it was to be expected that the toe of a labourer's boot was bound to have injured the external genitals, and that it could not possibly have inflicted a wound inside the vagina either with or without damage to the vulva. The explanation seems to be that in this case, as in a number of multipara, there was a slight prolapse of the anterior vaginal wall, which caused the lower inch, or inch and half of the anterior column to protrude through the vaginal orifice, when the woman was standing up. A kick when in the erect position, with the legs separated, if it took effect in the middle line, would drive the protruded portion against the pubic arch, cutting it like a knife. The patient being examined lying down, the wound would be found inside the vagina, and the inference would be that it must have been inflicted by some instrument introduced within that canal.

In the second case the injury was the result of accident. A servant girl, putting up window curtains, doing what she was warned not to do, stood on the flat top of a step-ladder. She slipped and fell straddleleg, the corner of the flat top of the ladder evidently struck her inside the right labium majus. The bleeding was severe but not excessive. She was brought into town and I was sent for to see her. A cursory examination showed grave injury, and I had her at once removed to the Galway hospital. Though she had lost much blood she was not collapsed, and was at once put under ether. The wound and genitals were thoroughly irrigated and cleansed. I found a wound extending from a little below the level of the posterior margin of the vaginal orifice, on the right side of, and within, the vulva, to the level of the pubic arch; its depth at the lower angle was an inch, getting deeper as it passed up, till it attained a depth of quite three inches at its upper angle; nor was this all, for it penetrated under the tissues and on passing my finger up, I found the pubes laid bare up to the middle margin of the symphysis. The urethra had been torn from its attachments and pushed downwards and over to the left side. The vagina was also displaced and the hymeneal attachment above, to the right and about half way below, torn from the vagina. The hymen was a very perfect one, with a small oval central opening, and could be lifted up, like the lid of the nest of the tarantula spider. I first sutured the deep portion of the laceration under the pubis; I next passed a deep suture along the side of the urethra and out at the upper angle of the wound; another at the anterior margin of the urethra emerging in the vestibule, thus bringing it back to, and fixing it in its normal position; and a lateral suture, immediately below the urethra, brought the edges of the wound into apposition to the level of the vaginal orifice. A few fine sutures were then introduced attaching the separated hymeneal margin to its position below the urethra, and at the side; a couple of sutures through the margin of the hymen, along the separated portion of the vagina, under the bottom of the wound, and emerging at the edge of the tear, closed the wound and brought the vagina back to position. The wound was kept constantly irrigated during the stitching, and a catheter was tied in for the first twenty-four hours. Except that the patient was rather collapsed, and vomited a good deal for twenty-four hours, there was no trouble, the wound healed without any suppuration; there was no rise of temperature, the hymen united at the torn margins; and when she left the hospital it needed a close examination to detect any trace of injury.

The restoration of the hymen may possibly be regarded as trivial, but I believe that when dealing with unmarried women we are bound, if possible, to restore the parts to the condition they were in before accident or operation, and I was induced to expend some time and care in suturing the hymen to its severed attachments from my experience in another case, with a very well developed hymen, in which when operating for stenosis of the cervix, I incised the hymen on both sides, making a posterior flap, which, after completing the operation, I replaced, suturing the cut edges. Union was perfect, not even a nick in the circumference of the aperture marking where the hymen had been cut.

Clinical Records.

THE WESTMINSTER HOSPITAL.

A Case of Ulcerative Endocarditis treated Successfully with Antistreptococcic Serum.

Under the care of Dr. MURRELL.

[Reported by Mr. G. W. HERON, House Physician.]

E. E., æt. 22, female, was admitted to Westminster Hospital under Dr. Murrell, on January 4th, complaining of pain and swelling of ankles. She stated that she had rheumatic fever at the ages of fourteen and seventeen, the first attack accompanied by chorea, and off and on since she had had rheumatic pains in the joints. A fortnight ago she developed another attack of acute rheumatism, during which she suffered from dyspnoea and palpitation with præcordial pains, these latter persisting up to the time of admission.

Her temperature on admission was 101.4°, pulse 64. The cardiac dulness was increased, the apex beat being diffuse, and the maximum impulse being just external to nipple line. A mitral systolic murmur could be heard at apex. She was treated with salicylates, and the pain and tenderness of ankles subsided after a week, but the pyrexia persisted, varying from 102° to 99°, remittent in type. This continued for four weeks. The condition of the heart during this time remained the same, and no cause for the temperature could be found in the lungs or elsewhere. The patient at the same time did not suffer from malaise, and her appearance was satisfactory, though becoming more pallid towards the end of the month. On February 6th, 30 c.c. of antistreptococcic serum (Burroughs and Wellcome) were injected under the skin of the abdomen. This had no influence on the pyrexial condition, which was, if anything, more persistently elevated than before, reaching 103.6° on two occasions. The serum caused a slight erythematous rash. Two days after the injection she developed an embolus at the bifurcation of the right brachial artery with obliteration of the radial and ulnar pulses, accompanied by considerable pain and tenderness at the bend of the elbow and in the forearm and hand, which the patient mistook for rheumatism. There was for some days a tender swelling at the situation of the embolus, but no suppuration ensued. By this time she had become pallid, and her general condition was becoming serious. The systolic bruit at the apex also changed in character, a pre-systolic being superadded; the palpable apex beat at the same time being further displaced to the left. The pulse varied between 116 and 124.

A week subsequent to the first injections a second was administered again of 30 c.c., but this time of the Pasteur Institute antistreptococcic serum. Four days later the temperature fell somewhat suddenly to normal and continued so for eighteen days. Her general condition at the same time markedly improved, the palpitation and præcordial pain subsiding, and a good pulse of under 90 being maintained. On the eighteenth day of convalescence the right ankle became swollen and painful, and her temperature rose to 101°, the condition being manifestly rheumatic. She reacted well to salicylates on this occasion, and the first trouble subsided in a day or two. Subsequently to this she made an uninterrupted recovery.

The case is interesting, first, inasmuch as it presents a typical example of the rheumatic diathesis with its various manifestations, of acute rheumatism, chorea, sub-acute rheumatism and simple endocarditis, culminating in an acute attack accompanied by ulcerative endocarditis. Secondly, by reason of the illustration it gives of the advisability of testing the therapeutic value of the various brands of serums in rotation in each individual case of ulcerative endocarditis, in hopes that one may be found to be antagonistic.

THE Clothworkers' Company has forwarded to the Mount Vernon Hospital for Consumption and Diseases of the Chest a donation of £50 in response to its appeal for £100,000.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON.

A MEETING HELD FRIDAY, APRIL 14TH, 1905.

The President, Dr FREDERICK TAYLOR, in the Chair.

Prof. HOWARD MARSH described a case of
AN AFFECTION OF THE KNEE-JOINT, POSSIBLY DUE TO
MALARIA.

The patient, a man, æt. 38, had had syphilis and had lived abroad. In April, 1903, the knee for three weeks had been the seat of such severe pain that he got no sleep. A few months later the pain was so intense that morphia was injected hypodermically. The joint, however, remained cool, movable, and very little swollen. In December, 1903, the joint appeared natural but the muscles were very much wasted and so weak that he was unable to raise his heel from the bed. He complained of such agonising pain from his hip to his ankle that he was even ready to submit to immediate amputation. In the evening I found that the joint had undergone a remarkable change since the morning. It now measured $1\frac{1}{2}$ inches more than the other, and the swelling was such as I had never before met with. It followed exactly the limits of the synovial membrane and within this area was so abrupt and prominent that the joint had a remarkably globular appearance. There was no fluid in the joint and the swelling seemed due to vascular turgescence of the synovial membrane. The patient stated that the joint swelled up in this manner every evening, and then gradually returned to its natural size. Knowing this quite definite periodicity and finding that he had often had malarial fever, he was given quinine in 10 gr. doses twice a day. Next morning his pain was gone and he had slept soundly all night. The pain did not return. In four days the attacks of swelling had disappeared, and he recovered muscular power in the limb so rapidly that in three weeks he was able to walk three or four miles without any bad results. The periodic swellings never returned. Six months later he had a patch of swelling covered by overwarm and intensely hyperæsthetic skin just over the internal malleolus. This swelling Dr. Tatham found was much more pronounced and much more painful at night. Quinine was again prescribed in 10 gr. doses and the pain was immediately relieved and the swelling gradually disappeared. At the present time the knee is perfectly well.

Remarks by Prof. MARSH.—I am aware that much that has been written on the subject of masked ague has been fanciful and erroneous. I ought at once to say that when the blood was examined by Major Ronald Ross no parasites were found. The swelling of the knee in this case was periodic, recurring at intervals of twenty-four hours. It was attended with very severe neuralgic pain. When quinine was given both the pain and the swelling forthwith disappeared. Is it possible that these symptoms were due to malaria, and was the case similar to those in which patients with malaria have been attacked with coma. Dr. Hilton Fagge records a case in which a patient after an attack of chilliness, nausea, and headache became extremely hot and passed into one complete coma with deep snoring as if in an apoplectic fit. The next morning he was perfectly well. The day but one after the same symptoms returned and were met with the same treatment, but when the third attack came on Graves saw that it was an attack of *tertiana soporosa*, and cut it short with quinine. Further I have read of two soldiers in a malarial district who underwent amputation through the thigh. In both for several days the stump each day became painful and engorged and dripped blood freely, so that the patients' lives were in danger. Then large doses of quinine were given. The result in both cases was immediate. The swelling ceased, no further bleeding occurred, and the patients recovered. All these cases were very similar. They were examples of localised vascular engorgement, periodic in its occurrence, and controlled by quinine. The pain which my patient suffered was periodic and intense and

immediately relieved by quinine. In these features it strongly resembled brow ague and other forms of neuralgia which are generally attributed to malaria. The condition of the muscles is deserving of notice. The wasting and loss of power were both extreme, yet three weeks after the patient was unable to raise his heel from the surface of the bed he was able to walk three miles without difficulty or fatigue.

SIR PATRICK MANSON remarked that Mr. Marsh had again raised a question which had been often discussed, but never settled, namely, the position of certain irregular manifestations of malaria. There were two ways in which these manifestations may be related to malaria: first, as a direct symptom of the disease, and secondly, as a condition due to the lowered vitality caused by the malaria. Thus syphilitic or other poisons produced a greater effect in a person who had had malaria than in a healthy person. In Mr. Marsh's case he could see no reason for supposing that the joint condition was due to malaria, as the patient presented no symptom which was pathognomonic of that disease. The periodicity was quotidian, a periodicity which was common to many conditions, and was usual in all septic fevers; in malaria it would be typically tertian or quartan. The exacerbation of symptoms was in the evening, which was a common event in syphilis, but very rare in malaria. The typical feature of malarial symptoms was their occurrence before mid-day. There was no other manifestation of malaria, such as fever, enlargement of the spleen, &c. He paid less attention to the absence of the malarial parasite, for quinine had been previously administered; it would have been very useful to have examined the blood before this administration. He would like to know how recently the patient had been exposed to malarial infection, for, in his experience, no active evidences of malaria ever occurred after three years at the utmost from such possibility. He referred to various conditions that had been termed irregular malaria, notably periodic nervous, cutaneous and gastric symptoms. He did not know of any that had had the two great malarial tests applied to them—viz., finding of the parasite and observance of the malarial periodicity. He only knew of two instances, one of a case of urticaria, and one of a case of irregular eruption, in which one of these tests—the characteristic periodicity—had been observed.

Col. MULRONEY, I.M.S., quoting from his large experience, said that malaria was often complicated by syphilis, the manifestations of which were always more decided than in non-malarious subjects. Often quinine relieved such cases, but only temporarily. Iodide of potassium was necessary to cure them permanently.

Prof. MARSH, in reply, thanked Sir Patrick Manson for the information he had given them. In his cases there had been no enlargement of the spleen, and over three years had elapsed since the man had been abroad. Prof. HOWARD MARSH described

THREE CASES OF INTERMITTENT HYDROPS OF THE JOINTS.

Case I.—An unmarried woman, æt. 28, was admitted into hospital in 1903 with the history that for eighteen months her right knee became swollen and painful every fourteen days. The swelling which recurred with strict periodicity lasted for three days and then disappeared, leaving the joint in what seemed to be a perfectly normal condition. While under observation for six weeks the patient had three attacks. Two were punctual to the day, whilst one which was due on a Saturday occurred on the Sunday—one day late. The effusion reached its acme on the second day, and then subsided so that on the fourth day it disappeared. The attacks were all exactly alike. The joint grew uncomfortable and stiff and the synovial cavity became somewhat tensely distended. Some fluid was removed and examined. It was reported to be merely synovial, diluted with serum. Various measures were tried, without benefit, but after taking small doses of arsenic, with occasional interruptions, for six months, the patient wrote (January 1904) saying the attacks had ceased. *Case II.*—A gentleman, æt. 42, between May and December had fourteen attacks of swelling in

both knee-joints. All these attacks occurred strictly on the fourteenth day with the exception of four which fell, one on the 13th, two on the 17th, and one on the 18th day. During the attacks the joints were loosely distended with fluid, but they were freely movable and quite painless. During the intervals they appeared to be normal except that they were a little weak. Arsenic in small doses was prescribed and continued for six months with occasional interruptions. The attacks ceased at the end of 1904. *Case III.*—A schoolboy, æt. 16, had effusion into his right knee-joint on the first occasion after a wrench at football, which recurred periodically every twelve days for a term of six months. During the attacks the joint was loosely distended, the movements were free, and there was no pain. The attacks lasted for three days. Arsenic was prescribed. The attacks became less frequent and ceased in the following November. *Remarks.*—These three cases were in all their essential features very similar to each other. The joint effusion returned with remarkable periodicity; in two every 14, and in one every 12 days. In all, the local condition, mere increase of synovial fluid, was the same. In all, the joints seemed normal in the intervals. These cases were typical instances of the usual form of intermittent hydrops and they closely resembled those which were observed or recorded by Drs. E. J. Brackett and F. I. Cotton and published in the *Boston Medical and Surgical Journal* in 1901. In the examples therein recorded, while the periodicity was always marked, the intervals between the attacks varied in different individuals from three or four days to thirty days or more. The most frequent interval was fourteen days. In some the interval changed from fourteen to two days. In several the attacks continued for three, four, or even more years. In several the attacks after persisting for many months ceased for some weeks or months and then reappeared. Some cases after showing definite periodicity lost this feature and the attacks became irregular, both as to the time of their recurrence and their severity. Our knowledge of the pathology of the condition is nil. Arsenic was the only agent which appeared to be useful. These cases are not only interesting on their own account, but because they may lead to errors in practice, for the recurring effusion might very well suggest the presence of a loose cartilage, or a synovial fringe for which a useless operation might be performed.

Mr. F. C. WALLIS suggested puncture of the joint as a line of treatment, and also with a view to the examination of the fluid. In his opinion, such conditions were of infective origin.

Dr. F. T. POYNTON pointed out that micro-organisms in joint affections were commonly confined to the sub-endothelial layer, and were rarely found in the fluid. He was not of opinion that the cases described were of microbic origin, but rather of the nature of an œdema or urticaria. It was well known that other conditions, notably the subcutaneous injection of such antitoxic sera as those of diphtheria and tetanus, could produce synovial effusion.

Dr. FORBES ROSS thought that the effusion was probably a serous hæmorrhage into the joint, due to a diminution in the coagulability of the blood. Malaria was known to predispose to this condition, and œdema often occurred in such subjects after the administration of mercury. This would account for the good results obtained by arsenical treatment, as arsenic, by diminishing metabolism, certainly increased the coagulability of the blood.

Dr. FREDERICK TAYLOR asked on what grounds arsenic had been given?

Prof. MARSH said that those who had seen many of these cases recommended arsenic, but many cases did not improve with it, whereas most cases spontaneously improved. He did not think that the condition was of infective origin, for there was no structural alteration of the joints, even after repeated attacks. He had not examined the fluid or the blood in his cases. Dr. Garrod had told him of three cases he had seen, two of which were the direct sequelæ of gonorrhœal rheumatism.

Dr. F. J. STEWARD described
TWO CASES OF HYDRONEPHROSIS DUE TO MOVABLE KIDNEY.

These two cases were brought forward to show the marked degree of hydronephrosis that can be caused by undue mobility of the kidney, which results in the formation of a sharp kink in the upper part of the ureter as described by Gigon in 1856. The first case was a young woman, æt. 20, who had had attacks of pain in the right loin for eight weeks before admission in February, 1900. A large, freely movable, fluctuating tumour was found in the right loin. The tumour varied somewhat in tenseness but never disappeared, the pain being worse when the tumour was most tense. The tumour was explored through a lumbar incision and found to be a large hydronephrosis caused by a sharp bend in the upper part of the ureter which was easily straightened out by pushing the kidney up into its normal position. The kidney was fixed by silk sutures to the parietes and the wound closed. The patient had no further pain, and the average daily excretion of urea increased from 167 grains to 277 grains. On examination nine months later the tumour was found to be markedly smaller, but it had not disappeared. At the present time, five years after the operation—the patient reports that she is quite well and has had no further attacks of pain. *Case II.*—A young woman, æt. 18, was admitted sixteen weeks after a right-sided hydronephrosis had been opened and drained. No tumour was evident until the tube was removed, when a large hydronephrotic sac became rapidly distended, and was then found to occupy a position considerably below that of the normal right kidney. On exploration through a lumbar incision the hydronephrosis was found to involve chiefly the pelvis. The cause of the condition was found as in Case I. to be a kink of the upper part of the ureter which was straightened out by pushing the kidney upwards. The kidney and upper part of the ureter were fixed to the parietes and a catheter passed down the ureter from the old drainage opening in the convex border of the kidney. The catheter was removed twenty-four hours later. The wound healed rapidly without further leakage of urine or distension of the kidney. Six months later there was no return of the hydronephrosis and the kidney remained firmly fixed in its normal position.

Mr. CLEMENT LUCAS was familiar with the condition, and related several cases. In one he had watched the gradual destruction of the kidney going on, the patient refusing operation. Intermittent attacks of pain frequently accompanied the actual kinking of the ureter. The inconvenience of this sometimes disappeared during pregnancy, the kidney being held in position by the gravid womb. He laid stress on the importance of preventing the condition by fixing operations. Often, however, the kidney was fixed in the wrong situation—too low down, with the result that recurrence took place.

Mr. WILLIAM TURNER related the details of a similar case he had operated on recently. He speculated as to the mode of infection that converted a hydronephrosis into a pyonephrosis.

Dr. FORBES ROSS pointed out the importance of the direction in which the kidney subsequently shrank. If it shrank down and out, kinking occurred. As one could not foretell this direction, would it not be better to adopt Mr. Thornton's proposal of examining the opposite kidney by laparotomy, and then removing the hydronephrotic kidney?

Mr. STEWARD, in reply, said that the unusual feature of his cases was the great size the tumour attained, for most often the kinking became so absolute as to destroy the kidney before this could take place.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING HELD AT MANCHESTER, ON FRIDAY, APRIL 14.

DR. LLOYD ROBERTS in the Chair.

DR. HELLIER (Leeds) narrated a case of "metror-

rhagia," associated with hæmorrhage into an ovarian cyst the size of an egg. The bleeding occurred quite apart from menstruation, lasted twelve days and was very severe. The patient was a young unmarried woman.

Dr. FITZGERALD (Manchester) showed a "Hæmatoma of the broad ligament," which appeared to have been formed in connection with torsion of the Fallopian tube in a woman, æt. 42, who had ceased to menstruate for some months.

Dr. WATTS (Manchester) showed three uteri removed from patients past the menopause on account of bleeding, accompanied by enlargement of the corpus uteri. All proved to be examples of cancer of the body. It was easy to curette in such cases without obtaining any evidence of malignancy, and bleeding, together with enlargement after the menopause, was sufficient to justify removal of the uterus.

Dr. GRIMSDALE (Leeds) related a case of intra-peritoneal rupture of the bladder during the first stage of labour in a primipara. On opening the abdomen later a brown discoloured area was seen at the fundus of the bladder, in the centre of which was a perforation. A gallon of urine was removed from the peritoneal cavity. The bruised area was excised and the wound was closed with fine silk. The patient made an easy recovery.

Dr. A. J. WALLACE (Liverpool) read a paper on REMOVAL OF THE CANCEROUS CERVIX BY THE ABDOMINAL ROUTE WITH PELVIC DISSECTION.

The paper was based on an experience of ten cases. Beginning with the pure abdominal route, Dr. Wallace had been led to employ the combined operation in preference. The uterus, adnexa, pelvic connective tissue and glands were first freed by laparotomy, and then extracted per vaginam. Details of the cases were given. Three operations were incomplete. Out of the ten cases the iliac glands were cancerous in three. The right obturator gland in another. In two cases the glands were diseased, although the primary lesion was in an early stage, the uterus being freely movable and all signs of infiltration being absent. Dr. Wallace considered that in properly selected cases the combined operation promised better chances of success than those afforded by the vaginal route.

Sir W. J. SINCLAIR condemned the operation on the ground that cases which cannot be dealt with by vaginal hysterectomy, aided if necessary by para-vaginal section, are not suitable for operative treatment at all. The mortality of the operation under consideration was very high, and many of the patients who recovered suffered from urinary fistulæ, which rendered their lives a burden. Many of the cases reported by foreign operators were simply unwarrantable vivisections.

Dr. H. BRIGGS had not done this operation, and did not contemplate doing so. He considered any advance in operative technique should be made strictly upon the lines of progress in general surgery.

Dr. A. W. W. LEE pointed out that Sir William Sinclair is in the habit of treating by vaginal hysterectomy many cases of cervical carcinoma which would be regarded as inoperable by the majority of ordinary gynaecologists.

ULSTER MEDICAL SOCIETY.

THE Ninth Meeting of the session was held in the Medical Institute, Belfast, on Thursday evening, April 13th, the President, Dr. WILLIAM CALWELL, in the chair. A letter from Dr. Leonard Kidd, Enniskillen, regarding the direct representation of Ireland on the General Medical Council was read, and after considerable discussion it was moved by Dr. J. Walton Browne that it was premature for the Society to make any pronouncement on the subject. This was seconded by Dr. Dempsey and passed.

Mr. R. J. JOHNSTONE, F.R.C.S., read a paper on

URINARY FISTULÆ,

which we hope to publish in an early issue. The paper was criticised by Drs. Dempsey, Walter Browne, and Kevin.

Dr. J. SINGLETON DARLING (Lurgan) described a case of

DOUBLE UTERUS AND VAGINA.

The patient was a young woman, æt. 23, who had been married three years, and who came to consult him on account of sterility. Menstruation was normal. On examination he found the first $\frac{1}{2}$ or $\frac{2}{3}$ inch of the vagina normal and above that a condition best likened to a double-barrelled gun, the two sides being separated by a thick antero-posterior septum. There was a separate and distinct os on each side. The condition, though not unknown, was sufficiently rare to induce him to bring it before the members of the Society.

A paper by Mr. Robert Campbell, F.R.C.S., on "Surgical Cleanliness," was postponed to the next meeting, owing to the late hour of the evening.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, April 16th, 1905.

TREATMENT OF HICCOUGH.

HICCOUGH is a phenomenon not always easy to determine the cause and frequently difficult to cure. Professor Robin, in one of his clinical lectures, cites the case of a man who came into the hospital three times for this affection. Anti-spasmodics were employed, but they seem to have rather accentuated the spasms. A closer examination revealed that the patient suffered for some time from dyspepsia, which was probably the exciting cause. Mr. Robin prescribed consequently, and with success, five drops, four times a day of the following mixture:—

Picrotoxine, 1 gr.;
Proof spirit, q.s.;
Hydroch. of morphia, 1 gr.;
Sulph. of atropine, 1-5 gr.;
Ergotine, 15 gr.;
Cherry laurel water, 3 drachms.

And the following powder:—

Calcined magnesia, 30 gr.;
Bicarb. of soda, 20 gr.;
Lactose, 20 gr.;
Codeine, 1-5 gr.;
S.n. of bismuth, 15 gr.
Chalk, 15 gr.

For one powder, three daily.

At the end of two days of the treatment, the patient left the hospital cured.

LUPUS VULGARIS.

Various treatments have been at all times tried for the cure of lupus vulgaris, but one of the simplest and at the same time the most efficacious is an ointment composed of arsenic, 15 gr.; vaseline, 1 oz. The parts are rubbed with a small plug of cotton charged with the ointment for five or eight minutes every three or four days. The patients feel at first a slight burning sensation, soon followed by more or less congestion of the region. Later, and as the treatment is continued, the lupus gradually disappears, leaving a very superficial cicatrix.

FORMIC ACID.

Professor Huchard presented at the meeting of the Academie de Medicine a paper on formic acid and formiate of soda, which he avers is an excellent muscular tonic. Its action is remarkable, almost extraordinary, since this agent increases the strength of the muscles in considerable proportions (five-fold), it increases the resistance of fatigue. His attention was drawn to it by Professor Clement, of Lyons, and to control the assertions of his colleague, he prescribed it in his hospital practice, and his experiments confirmed those of M. Clement. However, he prefers giving formiate of soda to a mixture of formic acid and bicarbonate of soda, as being more agreeable to the taste. The dose is about 15 grains three times a day.

Formiate of soda, 10 drachms;
Syrup of bitter orange, 10 ozs.

Three tablespoonfuls daily.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, April 16th, 1905.

At the Free Society of Surgeons Hr. Edm. Meyer showed some cases illustrating the

TREATMENT OF STENOSIS OF THE TRACHEA.

All of these had had a tracheal fistula, one for seventeen years, one for thirteen, and one for some months. In all cases there had been cicatricial stenosis. It was all-important that the site of this should be most accurately located by the tracheoscope before any attempts at its relief were made. In all cases the fistula was successfully closed without transverse resection of the trachea. The cicatrix was excised, and after appropriate after-treatment the fistula closed. In the after-treatment in one case, where the cicatrix was immediately below the larynx, O. Dwyer's intubation was made use of, the advantage of which was that the tube could be kept in days, and even weeks, together. In the other cases Schrötter's, as well as metal bougies, were used. The glass tubes of Mickulicz had not proved themselves suitable.

Hr. Bockenheimer related a case of

OSTEOMYELITIS CAPITIS.

A painter fell from a scaffold on to his head and remained unconscious for a quarter of an hour, then rose, and went to a surgeon. The surgeon found a wound on the left parietal bone which healed in a week. A fortnight later an abscess appeared which was opened. After this no improvement took place, the left side of the head remained oedematous and tender to the touch, and the patient suffered from intense headache. Then came on fever with rigors and symptoms of cerebral pressure. An opening was made; the bone was discoloured and matter oozed from it. The whole left side was now opened up and a fissure was found in the parietal bone from which the infection was supposed to have started. The external table was chiselled off and a sequestrum of the inner table found that was loosened and removed, after which the dura mater, which was also discoloured, was punctured, but nothing came. Some more sequestra came away later on, and recovery took place within about four months. The bony defect left was covered in by a flap, after the Müller-Koenig method.

The *Therap. Monatschrift* contains a note on the THERAPEUTICS OF CITARIN.

by Dr. Praslo, of Scheessel, detailing its effects in a number of cases which are reproduced below. Citarin has now been in use for some time, and one advantage it has is that it is not in the least disagreeable to take. The cases on the whole leave an impression on the mind that it is of considerable therapeutical value.

Case I.—A physician, *æt.* 40, had previously had two protracted gouty attacks, one involving the left shoulder and the other the left foot. Besides, he had been frequently troubled with violent lumbago and sciatica, which at once crippled him. In the course of the winter he had an attack of gout involving the left index finger, with swelling and marked pain, preventing sleep. Citarin, about 2 drachms in divided doses, caused a subsidence of these symptoms in the course of twenty-four hours. After eight days the symptoms recurred more intensely, and the same dose, about 2 drachms, daily, reduced to about 1 drachm in the following days, produced a permanent improvement. The dreaded lumbago, which otherwise necessitated morphine injection, had now made its appearance, and he was already limping about, but about 2 drachms of citarin again relieved this attack, as well as the recurrence which immediately followed. Owing to the persistence of the latter the drug was continued for another two days in doses of 30 grains.

Case II.—An old but vigorous gentleman was seized with his customary lumbago, which he ordinarily had to endure for fourteen days. Under citarin, 90 grains, it was arrested in two hours, when administered on the fourth day. The same patient had a paralysing weakness of the left foot which began to swell, and soon typical symptoms of podagra ensued.

During three days he took about 1 ounce of citarin in divided doses, and recovered at the end of that time.

Case III.—A man, *æt.* 60, who suffered with arthritis of the knee, with deformity of the joints on the right side, compelling him to walk with a cane, was seized with a violent attack of pain in both knees, which began to swell. Every night he took about 1½ drachms of citarin, and was now able to bear the pains, which disappeared at the end of three days. The deformity, of course, persisted, the case being probably one of arthritis deformans.

Case IV.—A robust butcher, *æt.* 40, was seized for a second time with a swollen foot, which caused intense pain and compelled him to lie down. He regarded it as due to over-exertion, but his physician diagnosed a typical attack of podagra. Citarin, about 2 drachms daily for two days, enabled the patient to again walk about, and after the use of an electric sweat bath he had no further difficulties.

Case V.—A man, *æt.* 56, who had previously suffered from gout, was seized with a very severe attack, every movement of the arm causing very violent pain. Although sodium salicylate had formerly proved of service, it now failed. He was given during three days about 6 drachms of citarin, and at the end of this time the pain had subsided, so that he was again able to dress himself.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, April 16th, 1905.

CANCER AQUATICUS DEFORMANS.

EISELSBERG presented a case of nomatose deformity of the face to the members of the Gesellschaft, which had been operated on with beneficial result. The patient was a male, *æt.* 40, and when seven years old suffered from an attack of typhoid fever. On his recovery an eruption appeared on the side of the mouth, and rapidly invaded the cheek, destroying a great amount of tissue. Fifteen years ago the deformity was so great that the patient was unable to masticate or make any movement with the jaws. It was resolved at that time to try some plastic operation, which was done after Gersuny's method, and has now fulfilled more than was expected of the meloplastic undertaking at that time. The face has a natural appearance, and the patient is now able to chew and do any normal operation with the mouth.

Ranzi showed another case of a cosmetic nature, where he had removed an osteoma from the forehead with equally good results.

IOTHION.

Volk read a long description of his experience with iothion in Lang's clinic. This drug has been largely used by Finger and Pick, who applaud its virtues as an absorbent and glandular stimulant. It is a hydroiodate salt of an oily consistence, yellow colour, and slight aromatic odour. It is rapidly absorbed by the skin and as quickly eliminated by the urine. It may be applied in the form of a paint or in an ointment, with a lanoline or vaseline base. He has already used it in eighteen cases of syphilis at different stages of the disease, and his results are unquestionably good, and obtained without any bad effects on the digestion or alimentary canal; no iodide acne or dermatitis with vesicle disturbance. The effects were more particularly demonstrated in cases of hereditary syphilis, where multiple ulcerating gummas and lymphadenitis were present and infiltrated with fistulae. After twenty applications the patient was greatly improved, with the gumma disappearing and fistulae closing. The abscesses on the cranium in one case he showed had quite disappeared, leaving slight depressions in the bony surface. The Röntgen rays showed unevenness in the lamina externa where three of these abscesses had been, with a sequestra embedded in a fourth. On account of scrotal ulceration, right-sided castration had to be performed before commencing the treatment.

CONTRACTIONS FOLLOWING BURNS.

Silbermark brought forward a patient from Mosetig's

ward, where a peculiar form of cicatrization had followed a burn. The patient was a boy, *æt.* 10, who had been scalded over the abdomen and leg two years ago. There were large bands of cicatricial tissue extending along the upper and lower region of the body, as well as the fore part of the thighs. The genitals were held up in a thick fold of skin, and no scrotum could be found or cord passing from the groin into the testes. It seemed that in the healing the whole organ got tucked up in the bands of contraction while in bed, but after the patient began to move about the legs drew the contractions outwards, taking the genitals along with them, so that nothing appeared in the centre.

LABOUR PAINS AND NASAL SENSATIONS.

Jerusalem brought forward the recent hypothesis of relieving labour pains by painting the nasal septum. Fleiss was the first to exploit this physiological connection and Falkner followed him with a confirmatory test. Now we have the experience of Jerusalem in eighty cases from Chrobak's clinic. He goes further in his experiments, and relieves painful menstruation by painting the tuberculum septicum, which he finds is always swollen and tender under these conditions. His method of treatment to relieve this morbid disturbance is to paint the septicum with a 1 per cent. adrenalin in a 5 per cent. cocain solution. In cases of inflammatory or mechanical dysmenorrhœa, such as gonorrhœa or cervical stenosis, this cocain mixture is of no avail. Another experiment which he has largely used to prove this theory is to irritate the nasal septum *intra partum*, which he invariably found would produce abortion. This he was able to do with the assistance of the Faradaic current on turbin bones. In two cases, however, he was unsuccessful. He considers this the most scientific method of producing mechanical abortions.

ADENOMA SEBACEUM.

Riehl demonstrated from a weakly girl, *æt.* 15, a good example of Pringle's disease. When the girl was three years old round elliptical yellow vesicles appeared on the face, which subsequently formed into flat nodules, the largest of which were found on the nasal fold. The histological examination proved the nodules not to be adenoma of the sebaceous glands but only an abnormal accumulation of the secretions in the sebaceous and sudoriferous glands, which were enormously developed with fibrous tissue and blood vessels. The affection seems to be of congenital origin, and may be properly described as a sort of *nævus*. The treatment adopted may either be electrolysis or excision.

Operating Theatres.

NORTH-WEST LONDON HOSPITAL.

TUBERCULOSIS OF VERMIFORM APPENDIX—**MR. J. JACKSON CLARKE** operated on a patient, a boy, *æt.* 7, who had been under medical care since December, 1904. The history of the case began on December 18th, when patient, who was subject to constipation, was seized with pain in the right iliac fossa. Vomiting ensued the same day. Patient then looked ill; the temperature was 100°, the pulse 72. The tongue was dry and furred. The abdomen was flat above, but slightly distended below, the umbilicus. There was great tenderness over the right iliac fossa and to a less degree over all the distended part. At intervals of about fifteen minutes patient cried aloud, owing to attacks of pain. Rectal examination gave negative results. The treatment consisted in enemata, which relieved patient of some scybala, fomentations, and milk diet. For some time improvement followed, but on January 1st, 1905, a localised swelling formed at the outer part of the right iliac fossa. Next day Mr. Jackson Clarke operated, opening the abscess, which appeared to be of the ordinary kind, by the muscle splitting

method. A drainage-tube was inserted and the patient, who was in a very weakly condition, was returned to bed. Gentle, mild antiseptic irrigation was done every day, but the sinus did not close, and some discharge continued. Mr. Clarke decided to remove the appendix. More than a month after the first operation, the abdomen was re-opened in the line of the old incision, an elliptical area, including the mouth of the sinus, being removed. The cæcum was identified; the region of the attachment of the appendix was found to be adherent towards the pelvis, and on freeing it by the finger, a caseous area, which represented the estump of the appendix, was found in the wall of the cæcum. This was scraped away and the exposed surface carefully mopped with 90 per cent. carbolic and invaginated by a purse-string suture. The appendix was then found to be represented by a narrow caseous mass which stretched downwards into the pelvis between the bladder and the rectum, and which was closely adherent to both. For better access the incision in the abdominal wall was increased downwards and inwards, stopping short of the deep epigastric artery. The caseous mass was then carefully removed piecemeal with a sharp spoon, and the cavity lightly touched with liquid carbolic acid 90 per cent. The artery of the appendix bled and was sutured. A rubber drain was inserted, and the wound closed.

All discharge having ceased, the drain was removed on the fifth day. The patient gained rapidly in strength and weight, and left the hospital five weeks afterwards.

CHELSEA HOSPITAL FOR WOMEN.

HYSTERECTOMY FOR CERVICAL FIBROID.—**DR. A. GILES** operated on a single woman, *æt.* 34, who had been sent up by Dr. Angell James on account of difficulty of micturition; she had suffered from this for twelve months, and it came on in the form of attacks lasting several days at a time. The attacks appeared to have no relation to the menstrual period. On making a vaginal examination, the pelvis was found completely occupied by a large hard mass, in the middle of which the cervix could be made out. Bimanual examination showed that the mass was surmounted from the abdominal side by a small projecting portion, which was evidently the body of the uterus, and the case was diagnosed as a large cervical fibroid. There had been no increase in the menstrual flow. On opening the abdomen the fundus of the uterus presented; it was unusually small and was perched on a summit of a large tumour occupying the pelvis. The broad ligaments were divided near the uterus, the peritoneum was incised across the front and back of the uterus on the level of the upper part of the tumour, from which it was then peeled off posteriorly until the base of the growth was reached; the whole mass could then be brought up out of the pelvis. The uterine arteries were secured with forceps and the uterus tumour removed entire, the incisions passing across the summit of the vagina below the cervix. The vaginal walls were brought into partial apposition by means of mattress sutures, leaving an aperture for drainage; all vessels were ligatured, and the peritoneal flaps united over the stump by a continuous suture from side to side. The abdomen was closed in the usual way. Dr. Giles said that the cervical fibroids formed a class rather by themselves and were little understood until Mr. Bland Sutton had called attention to them a few years ago; they seldom attained a size larger than a cocoa-

nut, the limit being, in fact, determined by the size of the pelvis, of which the fibroid usually formed a kind of cast. This was shown very well in the present instance, and it was, he thought, interesting to note the flattening of the tumour on its left posterior aspect which marked the position of the sigmoid. These tumours, he pointed out, seldom gave rise to hæmorrhage, unless septic or degenerative changes supervened, but, as might be expected, their prominent characteristic was the production of pressure symptoms, consequently most of these patients complained of pelvic pain, constipation and bladder disturbance. When the tumour was still only moderately large it led to frequency of micturition; later on the patient was liable to attacks of retention of urine. In some cases these attacks were synchronous with the monthly periods, and were determined by the extra congestion incident thereto. The operation for the removal of a cervical fibroid, he remarked, was at one time one of the most formidable forms of hysterectomy, because, owing to the complete manner in which the tumour filled the pelvis, the sewing of the uterine arteries was very difficult; by adopting the plan of shelling out the tumour the operative difficulties were considerably diminished, because the tumour could then be raised out of the pelvis, leaving ready access to the vessels, but the operation was not quite so simple as an ordinary supra-vaginal hysterectomy, when the cervix was not affected.

The patient made an exceptionally good recovery.

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The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, APRIL 19, 1905.

EXTENSION OF THE PAY SYSTEM IN GUY'S HOSPITAL.

THAT ancient medical charity, Guy's Hospital, has been much before the public of late years. In spite of an enormous endowment a few years since, the authorities of that institution asked for and obtained a huge sum from the public. This year a similar request is being made to the inexhaustible generosity of our countrymen. The present moment, therefore, is opportune for inquiry into the relations of the great medical charities, of which Guy's Hospital may be taken as the type, to the public and to the medical profession. First, the ground may be cleared by acknowledging

freely that the scientific standing of Guy's Hospital is more than equal to the high standard that is naturally looked for from a centre of teaching and study rendered famous by ages of tradition. Let us now turn the searchlight of modern socio-economic analysis upon certain other phases of the administration of Guy's Hospital. First of all, we submit the proposition that the system of payment by patients in vogue at that institution is an injustice to the poor, a misuse of charitable money, and a grievous injury to medical practitioners. For many years this richly-endowed charity has been in the habit of extracting a money payment wherever feasible from out-patients for every bottle of medicine supplied to them. That, at any rate, was the case a few years ago, and we believe the same thing is still done. We cannot imagine that one in a hundred of the charitable persons who give their money to Guy's for a moment imagine that the poor patient going there is made to pay threepence for a bottle of physic, or else to submit to a humiliating cross-examination by a mendicinity officer. Does the King Edward's Fund appreciate the full gravity of that position? Is the Fund even acquainted with the fact before giving its grant to Guy's? Possibly the Prince of Wales may ascertain whether by taking off an unnecessary and wasteful extra threepence a pound spent upon beef it would not be possible to remit the threepenny tax off the medicine-bottle of the poor. We appeal to the whole of the Metropolitan Funds—the Hospital Saturday, the Sunday, and the King Edward's—to inquire whether Guy's Hospital has any effectual system whereby charitable medical relief is confined to the poor. If not, we say the hospital does not deserve a grant until some effectual supervision of the kind is adopted. As often insisted upon, the bestowal of charity upon those who can afford to pay for it robs the poor of money that has been subscribed for their use by the charitable, and, on the other hand, it takes the bread out of the mouth of the general practitioner, the bulk of whose income is in the majority of cases made up of small fees. We have no hesitation in saying that with a reasonable exclusion of improper cases Guy's Hospital would have no need to come periodically before the public asking for huge sums of money. The authorities seem to think that the hospital can disregard all outside interests in the attempt to increase its already vast income and expenditure. In order to swell available funds the Hospital years ago started wards for paying patients. That step clearly deprived the general practitioner of better-class patients. We submit to the King Edward's Fund that to use the money of the hospital to provide medical accommodation for gain is to trade on trust funds, and is a totally illegal step. The Funds have been forced to admit the illegality of handing hospital money over to medical schools. They would quickly find, were the question brought forward in the Law Courts, that the use of hospital money in what may be described as hotel ventures is no

less illegal. Guy's Hospital, however, not content with encroaching upon the income of the general practitioner, is now making a serious bid against the specialist and consultant. Having equipped an extensive electrical department, the management announce that patients may have "high frequency," radium, X-ray, electrical, and light treatments upon certain terms of payment. It is stated that this plan is advanced for the benefit of those who are unable to pay specialists' fees. At the same time, six guineas is mentioned as the maximum for a course. Can the King's Fund know what is going on at Guy's? If not, we beg that Fund, which we look to as a future bulwark for the protection of the medical profession, to inquire forthwith as to the working of the pay system at Guy's. At the same time, we may inform the Fund that there are plenty of specialists in the West End who would jump at the chance of a six-guinea fee. The whole thing is nothing short of an iniquity. First, the money of the charitable public is expended in equipping an extensive electrical department for the poor. In order to provide interest on the sum thus expended, to pay working expenses, and to swell the funds of the hospital, a formidable competition is started against the struggling outside specialist. Where is the thing to end? Is the hospital octopus to suck the life out of all branches of the medical profession except the operating surgeon? In conclusion, we may say that we have no animus whatever against Guy's Hospital, which is rightly regarded as a noble institution. We believe, however, that its best interests will be safeguarded only by a careful and conscientious regard for the rights of the rest of the world, including the medical profession, by whose gratuitous services Guy's is enabled to perform her great work.

MILK AND HYGIENE.

MILK is almost the one only staple article of diet which is partaken of without cooking or other process of preparation having the effect of sterilisation. It is, moreover, in cases where breast feeding is impossible or evaded, the exclusive food of infants at their weakest period of life. Further, it is the one food which is regarded as a necessity for all invalids, and on this account, considering their diminished resisting powers, there is all the more need that it be kept free of pathogenic germs. Nevertheless, there is no other article of food collected, handled, and stored with such an absolute neglect of hygienic precautions as milk. This is equally true whether one regards the city or the country dairies. The milk supply of all our large towns comes in the main, of course, from the country, but nevertheless there are in all of them city cow-houses to a considerable number. Thus, in Edinburgh, there are no less than 115 licensed cow-sheds, containing in all something over three thousand cows. Most of these sheds are situated in insanitary districts, hidden away between densely-populated tenements, approached by narrow lanes or alleys. The sheds are small and cramped, with bad light-

ing and worse ventilation. In many of those in Edinburgh, there is not more space than 400 cubic feet available for each cow—the same space as is obligatory for each sleeper in a common lodging-house. But the occupant of a lodging-house only spends seven or eight hours out of the twenty-four in such surroundings, whereas the unfortunate cow, at least six times his weight, is absolutely immured in the same shed for nine, twelve, or eighteen months, or even longer. Moreover, the removal of excrement is never complete, and the heap of refuse is often piled up within a few feet of the cowhouse. There is no difficulty in agreeing with the conclusion of Dr. Aitchison Robertson (a), based on an examination of the conditions in Edinburgh, that the effect of such environment must not only have a bad effect on the health of the cow, but that the quality of the milk must also suffer. In the country things are a little better, since only in the winter are the cows kept constantly indoors; in summer they have freedom in the open air both day and night. Neither in town or country, however, is there as a rule any care taken to preserve milk from contamination during milking and handling. The black sediment at the bottom of a tumbler or jug of milk is sufficient evidence of the amount of extraneous matter commonly present, and it must be remembered that it is only the heavier particles which, sinking to the bottom, attract notice. In truth, to be a spectator of the process of milking in an ordinary cow-house is almost to forswear the use of milk as a beverage. The milkmen and milkmaids are, for the most part, dirty and untidy in their persons, with filthy clothes and hands black with dirt. The cows are, as regards their flanks, legs, and even udders, encrusted with fæces. No attempt is made to cleanse either the udders of the cows, or the hands of the workers, and the milk as it falls into the open pail receives supplies of dust, dirt, and hairs from the cow. When one follows the milk from the byre to the distributing shop, one finds the same disregard for cleanliness and asepsis. Tracing it from its source to its consumption, there is no article of our diet which needs more careful supervision than milk, and in but few of our cities is this supervision given with thoroughness. It is worth while, too, impressing on dairy-keepers and milk-vendors generally that there is an excellent market for milk of guaranteed purity, and that such milk can be produced without any disastrous lavishness of expenditure.

THE DECAY OF THE FAMILY DOCTOR.

AMONG the signs of the times must undoubtedly be reckoned the gradual but distinct alteration that is taking place in the relationship of the public and the doctor. This alteration is one that must eventually lead to a re-casting of medical etiquette, unless the tide which is flowing in one direction soon begins to ebb in the opposite. The alteration is, we think,

(a) *Scottish Med. and Surg. Journ.* February, 1906.

intimately connected with the psychology of the period, and if this be so, however much it may be disliked and resented, there can be no hope of stemming or resisting it till the present attitude of people's minds to affairs in general undergoes a retrogressive metamorphosis. All change is not evolution, and all innovations are not reforms; it remains to be seen how far the newer aspect of medical relationships comports itself with the necessities of modern existence. The change we refer to is the subversion of the old, intimate, confidential reliance in the family doctor in times of sickness and trouble in favour of a hasty thirst after "specialists" of whom little is known personally, and with whom it is not desired that personal relationship should be extended beyond the precise degree necessary to eliminate the disease. Now there is doubtless a good deal to be said on both sides. The family practitioner, be he never so "up-to-date" as the barbarous current phraseology has it—cannot pretend to more than a general acquaintance with the manifestations of disease, and a passable skill in prescription and manipulation. It may be argued that for seven-eighths of the general practitioner's work this is all that is needful; and indeed so it is. The general practitioner has been described a "specialist in slight ailments," and no one would deny that most of the cases with which he is brought into contact are such as would have recovered eventually even had he not been summoned, though his presence may have added to convalescence the proverbial qualifications—*tuto, cito, ac jucunde*. There remains but one-eighth of his cases, and a small eighth at that, in which the well-informed and skilful practitioner could be advantageously supplemented by one of special experience, but even in these, though the element of safety, rapidity, and agreeableness may not attain their highest possible development, the general practitioner is still competent to bring them to a successful issue. For average folk this should be sufficient. On the other side of the picture stands the specialist, a strongly drawn figure. He no longer deals in generalities of any sort; he is a specialist for some particular corner or cranny of the body, and because he professes limitations to his knowledge, that knowledge is assumed to be complete within these limitations. Like Martial's *Græculus*, he knows everything—of his pet area of the divine human frame, and unfortunately he is sometimes *esuriens* as well. At least, the general practitioner suspects him of being; often it is true from the garbled account of his advice retailed by the patient. Whether the demand has created the specialist or whether the specialist has created the demand, the fact remains that people now want specialists for everything, and the *quondam* consulting physician or surgeon without a speciality is undergoing a process of extinction that cannot be described as euthanasia. Now, no general practitioner is foolish enough not to value the advantage of a

good expert opinion—on a difficult eye case, an equivocal rash, or an obscure tumour; he is only too glad to have his advice confirmed or his diagnosis aided. What he does object to is finding people whom he regards as "his patients" darting off to the West End whenever they have ear-ache or back-ache, or heart-ache, to an ear-specialist, a back-specialist, or a heart-specialist, who lays down a plan of treatment or advises an operation without the full knowledge and consent of the family doctor. Every specialist knows that three out of every four cases he sees in the morning are patients with more or less trivial derangements, whom any ordinary practitioner could treat successfully, but who have come up to have the "best advice." If, as we say, all this restlessness and impatience of the public is inevitable it will serve no good purpose to resist it, but it certainly saps the old-time confidence of patients in their doctors, and it certainly will not raise the faculty in public esteem. The result must be a more or less organised warfare between the general practitioner and the specialist, and of this signs are not wanting in the present day. There is a marked tendency to the formation of firms of doctors in large towns who aim at being more or less complete in themselves as regards specialities, and who take good care that none of their patients go to any other practitioner, general or special. There is, in fact, a sort of "trust" movement discernible in several cities, whose idea is to dominate and control the practice in the district and to freeze out the unlucky men who have the hardihood to practise on their own merits and on their own account. Such a commercial spirit is foreign to the best traditions of the profession; it is not "infamous conduct in a professional respect," but it falls far short of the old ideal of the conduct of doctors towards each other—the ideal that the practice of medicine was the service of humanity, and the claim of one doctor for preference to another consisted in his own deserts, personal and professional, rather than in his financial alliance with a particular clique of fellow practitioners. If the American business methods which have almost spoiled our morning papers are permanently to enter into the practice of physic, we believe the result will be not to the patient's benefit. It remains to be seen if this benefit will remain, as it has been in the past, paramount. From the patient's own point of view, Bacon's advice as to the choice of a physician has not staled, though three hundred years have elapsed since he wrote: "Take one of a mild temper, and forget not to call as well the best acquainted with your body as the best reputed of for his faculty."

THE Governors of St. George's Hospital, Hyde Park, have decided to make a special appeal for a sum of £350,000 for the purpose of rebuilding the hospital. The number of in-patients admitted to the institution in 1904 was 4,530, and the number of out-patients was 36,631.

Notes on Current Topics.

The Dangers of Pasteurisation.

IN view of recent investigations made by Dr. Pennington, of Philadelphia, it is likely that current views on the value of pasteurisation will have to be altered. The profession has for many years been in the habit of recommending the use of pasteurised milk for the poor of our large towns, and the daily papers, following the lead, usually sing its praises with loud dogmatism. It may be at once admitted that pasteurisation does not in any way alter the nutritive qualities of milk, whatever effect it may have on it from an æsthetic point of view. Moreover, there is no doubt that by pasteurisation the bacterial contents of the milk are for the time greatly diminished, and in so far danger of infection is lessened. Unfortunately, however, according to Dr. Pennington, the diminution of bacteria is only temporary, and pasteurised milk when examined a day or two after preparation is found to contain a larger number of bacteria than ordinary milk. The organism chiefly affected by pasteurisation, is the lactic acid bacillus, a bacillus which has the merit of making its presence felt by the acidity imparted to the milk. The products of the lactic acid bacillus are quite harmless, if, indeed, they have not the positive therapeutic effects imputed to them by Metchnikoff, and therefore it would seem that pasteurisation has the effect of destroying a harmless bacillus whose products, being easily discernible by their acidity, might act as a sign of the presence of other organisms, while it has no inhibitive power on the growth of these other possibly pathogenic organisms.

American Advertising.

OUR contemporary, *American Medicine*, publishes in a recent issue some examples of advertising in America, which help to make us contented that business methods here are still somewhat behind those of our "hustling" neighbours across the Atlantic. One of these advertisements, a circular distributed to the physicians of Providence by the proprietors of a certain pharmaceutical preparation, offers a reward of ten dollars to each physician who shall certify on a given form that he has ordered the preparation to a certain number of his patients. The advertisers claim that the proposal is "strictly ethical," but nevertheless it reassures us to learn from the circular that "there are a few physicians in Providence that have not taken advantage" of the firm's "liberal, profit-sharing offer." Another instance of American "pushfulness" is a circular from the proprietors of a sanatorium offering to join resources with private physicians in "landing prospective patients" by "starting after them with literature." Apparently the net is to be that of the physician, but the basket is the sanatorium. The most sporting offer, however, is that of a firm of undertakers of New York. This very enterprising firm has sent to the physicians and clergymen of New York "in appreciation for past courtesies," a

certificate entitling the holder to "one hundred dollars' worth of burial materials" for himself. The certificate is non-transferable, and holds good up to January 1st, 1910. But what are the "courtesies" which have so won the gratitude of these gentlemen?

Looping the Loop.

THE sudden death of a charming artiste in Paris last week will serve to draw attention to the terribly dangerous nature of such feats. As a matter of fact, the poor girl was simply found dead at the end of the circuit strapped to the automobile in which she made her perilous ride. The risks of the performance are more than recognised in the fateful descriptive title, "Whirlwind of Death," applied to the performance. It is interesting to note that some of the English newspapers, commenting on the incident, indignantly ask who are the culprits, and insist that the sensation-loving public are really to blame. It is doubtless desirable to detect the beam that decks the Parisian eye, but would it not be well for our Fleet Street journalists to consider a little the mote that disfigures our own insular vision? Not long ago a jockey was killed in view of a London audience while engaged in a terribly hazardous race on a revolving platform. As a matter of fact, the London County Council and local authorities generally have no powers to prohibit dangerous performances. Legislation is urgently needed in that direction. First, however, it will be necessary to rouse the public conscience as to the essentially degrading and demoralising nature of "shows" wherein the chief attraction is the jeopardy to human life.

The Metropolitan Asylums Board and Phthisis.

AN important deputation waited upon the Metropolitan Asylums Board on the 15th inst. It was organised by the Metropolitan Branch of the Incorporated Society of Medical Officers of Health. Many medical boards and societies were represented. A number of cogent arguments were advanced by various speakers, and to these we shall hope to advert more particularly in an early number. The chairman of the Asylums Board, Mr. A. C. Scovell, received the proposals of the deputation favourably. While expressing concurrence in the magnitude of the evil and of the defectiveness of present preventive measures, he appeared somewhat doubtful of the practicability of taking over the charge of tuberculosis in London. His most important statement, perhaps, was that regarding expenditure, and he questioned whether the public—the ratepayers of London—were yet sufficiently acquainted with the importance of the subject to induce them to assent to any extension of the rates. In conclusion, he promised that the matters urged by the deputation should have the most earnest consideration. In some ways this deputation may be regarded as marking one of the most important departures yet made in the systematic treatment of tuberculosis by the community.

Child-Suicide.

ONE of the saddest things in life is self-destruction, and it becomes incomparably sadder when the victim is not a broken and disappointed man but a child out of whose life the brightness that belongs in especial degree to the young has too soon given way to despair. During the last two months there have been recorded no less than seven suicides in children, and when it is remembered that these occurrences are not only experienced in this country, but in all civilised countries, and, moreover, that they are on the increase, it is high time to inquire into the causes that underlie them. In the *Deutsches Archiv für Kinderheit Kunde*, Dr. Deutsch, of Budapest, records two hundred cases of child-suicide on the Continent, and he notes that fifty cases were collected by Ferriani and forty-nine by Siegert. Various causes are assigned, and they are classed as predisposing, exciting, and general; but the fact that emerges most strikingly when these are reviewed is that the individuals are generally children towards the close of school-life, and the suspicion instantly arises whether it may not be that some of the circumstances connected with that period of existence are responsible for the mischief. In the opinion of some who have looked into the question, the stress of examinations and "cramming-up" is the most important single cause, whilst punishment, or the fear of it, poverty, and unhappiness at home all bear a part. The children who deliberately destroy themselves are seldom, or never, normal, but many of them are bright, intelligent, and well-disposed. To such there should have been a fair prospect of usefulness in life. Drowning is the form of death generally chosen, as being the most readily available, but poison, shooting, and leaping from heights are all recorded.

The Education of a Surgeon.

PROFESSOR SENN, of Chicago, whose opinions on all sorts of subjects seem to have a vogue in America almost equal to that enjoyed by Professor Osler, has recently been expressing himself on a question on which he is well qualified to give an opinion. He has, in fact, contributed to the *Monthly Cyclopædia of Medicine* an article entitled "The Training of the Modern Surgeon." He believes that the fault in present surgical education is the too early specialisation to which the would-be surgeon runs. Before all things, the good surgeon must be a good physician, and for this he must be thoroughly grounded in the fundamentals of medicine, anatomy, physiology, chemistry, bacteriology and pathology. This is certainly a sound foundation on which a goodly structure may be reared. In order, moreover, to gain this basis of knowledge, Dr. Senn suggests to the student the spending of half-a-dozen years after qualification in general practice before devoting himself specially to the study of surgery. In order to remind himself of the fundamentals,

which he has probably by this time half-forgotten, he should spend one or two years in the study of surgical anatomy and pathology, and during after-life he should frequently refresh himself by visits to scientific laboratories and the clinics of other surgical workers. While one may admit that Dr. Senn has sketched out an admirable scheme of education for an ideal surgeon, one may be forgiven for pointing out that life is short, and that it is hardly an equitable distribution of its scanty years to devote about half the proverbial three score and ten to preparation for the remainder. A man's life work must not be merely the occupation of his declining years.

A Medical Reform Bill.

THE Medical Acts Amendment Bill, drafted by the British Medical Association and now before the Divisions of that body, while it contains many points of great importance to the medical profession, is unfortunately weighted with certain provisions which are certain to procure for it bitter opposition in many quarters. The main attempt of the Bill is to restrict medical and surgical practice to properly-qualified persons, but even in this laudable effort the phrasing is so faulty as to render it penal for a mother to give a dose of castor oil to her child! An attempt is made to reform the General Medical Council by substituting direct representation for much of the present corporate representation, and to substitute a "One-Portal" system for the present illogical method of admission to the Register. The size of the proposed Council seems to us, however, to be unwieldy—forty-six members instead of the present thirty-three. In the distribution of these members, too, the interests of Ireland are entirely overlooked. Instead of, as at present, furnishing seven members to a council of thirty-three, she would furnish only six to a council of forty-six. If the control of a "One-Portal" system is to be given to such a body as this, including all that that control means in the way of appointing examiners, regulating courses of study, and so on, it is obvious that the passage of the Bill into law would mean serious injury to medical education in Ireland. It is not to be wondered at that the Dublin Division of the Association has expressed its disapproval of the Bill, and it is probable that the Bill will split on the same rock as its predecessor last year—the opposition of the Irish members at the Representative meeting.

Military Funeral for a Nurse.

IN a grey, sober-tinted life a dash of rich colour has a particularly warm effect, and life for most people in this temperate clime of ours in England is at the best a mixture of drabs and neutral-tints. A little show, music, and even display are all the more appreciated on that account, and their effect is both cheering and inspiring. There is no more impressive sight than a military funeral, unless it be, perchance, a funeral at sea, and few

who have witnessed the passage of the gun-carriage taking the coffin with its occupier's accoutrements, the riderless charger, the reversed arms of a reverent soldiery, and the muffled roll of the drums are likely to forget the pageant. Designed to do honour to the departed comrade, the military funeral cannot but have an elevating effect on those who have served with him, stimulating them to a greater sense of their duty and their responsibility. We take it as showing a new spirit, or rather a new manifestation of an old spirit, that a funeral with full military honours was accorded at Canterbury on the 6th of this month to Nurse Reed, of the Army Nursing Service Reserve, who fell as truly as ever soldier fell at the post of duty. Nurse Reed had been nursing a typhoid patient and, contracting the disease from him, she failed to weather the storm. But the military heart went out to her in recognition of the quiet, unsensational heroism through which she came to her death, and though no Army Order on the subject exists it was decided to give her a military funeral—carried out by volunteers from amongst those with whom she served. Colonel Hickson, C.B., and practically all the officers and men, acting on their own initiative, fell in, and the impressive ceremony was carried out to the last detail. The generous spirit thus displayed does honour as much to the doers as to the memory of the dead, and we cannot but hope that now that the nurse is embodied as an integral part of the constitution of the Army the precedent of Canterbury will be generally followed. The pageant of a military funeral will do good if it brings home to the onlookers that there are other enemies beside carnal ones, and that they are faced by those whose duty it is to face them as unflinchingly as ever soldier faced shot and shell and steel.

Prognosis in Epilepsy.

It is curious to notice that there has been no change for the better in the prognosis of epilepsy under the bromide treatment, if we are to judge by the percentages of cures recorded before and since 1857, when that treatment was introduced. Thus, before that date, different observers varied in their calculation of the probability of cure from Hufeland's 5 per cent. to Herpin's 50 per cent. Since 1857, Nothnagel suggests 4 per cent. of cures, Dana 5 to 10, Habermaas, 10, while the highest is 12.5 given by Alt. Dr. Aldren Turner, whose experience of epilepsy both at Queen's Square and Chalfont is very large, has contributed certain conclusions drawn therefrom to an American journal. (a) Leaving out of count all cases where the epilepsy was due to any obvious organic lesion, or was accompanied by any degree of idiocy or imbecility, he found that of those patients under observation for lengthened periods 10 per cent. recovered. With regard to his definition of recovery, he bases it on freedom from fits for a period

of nine years, since though relapses may occur after four, six, or seven years of freedom, they very rarely occur after longer periods. Nevertheless, even after very prolonged periods of freedom from seizures a relapse may occur, as happened in one case after twenty years, and in another after twenty-five. Curiously enough, the most unfavourable cases were those of *petit mal*, *grand mal* being much more amenable to drug treatment. The epilepsy of puberty and that of old age are both tractable, while that of childhood and of adult life are less hopeful. It is important to bear in mind that a family tendency does not, in many cases, offer any obstacle to the arrest of the disease under suitable treatment, but it does increase the likelihood of dementia supervening.

Eton's New Headmaster.

THE selection of a new headmaster for Eton in place of Dr. Warre was a task of no little perplexity and responsibility; we think the Governors have done well and wisely in choosing Canon Lyttelton. The post of headmaster at Eton is, as Lord Rosebery pointed out in his speech at the meeting to consider the proposed testimonial to Dr. Warre, one of supreme importance, as into the headmaster's hands falls the fashioning of future governors of the Empire. Privilege is not yet dead, wealth is very much alive, and while it is the fashion for rich men and those holding privileged positions to send their sons to Eton, a larger proportion of politicians and Colonial governors are likely to be trained there than at any other school. Eton has traditions, and of its traditions it is proud. It is hardly necessary to say that those traditions, extending back for unbroken centuries, are neither liberal nor progressive. Anybody that conflicts with these traditions is likely to have a rough time of it at Eton, whilst anybody that can show Eton boys that the face of the world has changed with the evolution of science and the rise of a new knowledge is likely to have a widely-reaching influence. Canon Lyttelton may not be a scientific man in the ordinary acceptance of the term, but he is as near being a scientific man as would be tolerated by Eton governors and Eton boys. One of the objections made when his name was mentioned was that he would have all Eton clothed in Jäger, instead, we suppose, of allowing youngsters of fourteen and fifteen to don those articles of clothing which their mature knowledge of hygiene would be likely to suggest. Another of Canon Lyttelton's shortcomings in the eyes of the old school was that he has ideas about diet, and is averse to over-much meat-eating. On the whole, we think, Eton is likely to be benefited in the near future with some fresh ideas about what is good for the body, and if Canon Lyttelton has the courage of Dr. Arnold as well as his ability, he may be able to turn out statesmen who do not regard territorial concessions in the Sahara of higher moment than the health, lives, and happiness of those dwellers in the heart of the Empire

(a) *Boston Med. and Surg. Journ.* February 16th, 1905

who sweat in stinking hovels and poison each other in over-crowded tenements.

The Mechanism of Asthma.

CURIOSLY little is known certainly about the precise mechanism of asthma. The matter has been ably dealt with by Inspector-General Hare, of Brisbane, in an original article which will be found elsewhere in the pages of our present issue (page 395). He points out the two antagonistic views which are held by different authorities, namely, that which attributes the bronchial constriction to the circular muscular fibres and the other which ascribes it to swelling of the mucosa of the bronchi. The evidence for and against these views is reviewed in a singularly able and learned article. His own conclusion is that the asthmatic paroxysm depends upon a special pathological variation of vaso-motor action. It is desirable that medical men should arrive at some settled convictions upon so important a subject. Until they arrive at the truth of the matter they must be hopelessly at fault in the treatment of asthma, inasmuch as muscular spasm and vaso-motor swelling demand therapeutic handling of widely differing nature. The determination of elementary scientific facts in so common a malady as asthma is allowed to remain in doubt while progress in medicine is left mainly to laboratory workers. A little reflection will show that great advances in therapeutics have been hitherto mainly due to the workers in the field rather than in the study armchair and the laboratory.

The Queen's Jubilee Hospital.

IN response to an invitation from the Board of Management, the King Edward's Hospital Fund have held an inquiry into the affairs of the Queen's Jubilee Hospital. Their report has been published with commendable promptitude. At the same time it is a document of an amazing character, and contains views and recommendations of an extraordinary and unusual nature that will require further careful detailed analysis. At the outset it lays down the proposition that a mere member of the Royal College of Surgeons of England is not competent to discharge the duties of surgeon to a hospital. We venture to say that many distinguished men have held and are holding hospital posts in Great Britain who possess no other surgical qualification. The gentlemen answerable for the report appear to be imbued with the narrow intolerance and selfishness that everywhere governs the medical world. They find that the hospital administration was lax, but they fail to insist that the laxity was mainly due to the negligence of the late staff. They indirectly condemn the action of the gentlemen who have accepted the vacant appointments, apparently regardless of the fact that the successors satisfied themselves individually of the *bona fides* of the hospital management before taking office. The report advises that the new staff and board should resign and that the hospital should be provided with a new board and a new honorary

staff to be approved by the Royal College of Physicians and Surgeons. To invite a medical charity to commit suicide in favour of autocratic irresponsible corporations seems simply grotesque.

Proposed Confederation of London Medical Societies.

THE proposal to join the forces of the London medical societies has been before the profession for the last forty or fifty years. It has certainly received a great stimulus by the large meeting held at the Royal College of Physicians on April 10th last. Sir Frederick Treves moved a resolution, which was carried unanimously, to the effect that in the opinion of the meeting it was highly desirable that an effort should be made to unite the principal societies into a new body, to be known as the Royal Society of Medicine. A second resolution, inviting certain societies and official bodies to co-operate in devising a scheme, was proposed by Sir William Broadbent, and also carried unanimously. A committee was then appointed, consisting of five members, with Dr. Arthur Latham as honorary secretary. Finally, it was determined to convene a meeting of the societies some time in July next, in order to receive the report of the committee. There can be no question as to the advantage that would accrue to medical organisation in London by the amalgamation of resources and the economy of united administration. It may even be hoped that the movement is a herald of the future millennium of universal peace and goodwill for medical men not only in the United Kingdom but also all over the world. Dr. Latham may be congratulated on having started matters on a businesslike footing, whatever the upshot of the amalgamation scheme may be.

The Tunnel Cure.

THE atmosphere of tunnels is not a popular respiratory medium. The majority of individuals take pretty good care to shut the windows of a railway-carriage tightly immediately the train enters a tunnel of any length, while some even go so far as to close those minute apertures in the sides and roof of the compartment which are dignified by the name of ventilators. Some varieties of coal consumed by the engine render the smoke far more offensive and irritating than others. Could the smoke be altogether abolished, the air of tunnels would not, perhaps, be so jealously excluded from finding its way into the human respiratory passages. In fact, the atmosphere of some underground subways is quite refreshing, its peculiar dankness and subterranean odour proving an almost welcome change after the ordinary air above-ground. At any rate, it is something of a novel experience, and, therefore, the tunnel may play a useful part in relieving the monotony of a long journey. Whether the air of tunnels possesses any special properties which endow it with some value as a therapeutic agent appears more than doubtful, but we are informed that "tunnel-air" has been recommended

for croupy affections of the lungs. The term "croup," being purely a clinical one, does not convey a very accurate impression of the class of pulmonary complaints that are supposed to be benefited by this extraordinary method of cure, but, presumably, asthmatic symptoms are more or less prominent features. *Apropos* of smoky tunnels, the news comes from Upper Silesia that consumptives coming to reside in the neighbourhood of the coal-mines have recovered their health, the creosote in the dusty air being supposed to have some drying and disinfecting effect upon the pulmonary lesions. We shall doubtless hear of the erection of sanatoria in their vicinity.

Drug Companies.

AN important question that is likely to come even more to the fore in the future is the position occupied by the various companies that now trade as pharmaceutical chemists. These companies are able, by reason of having many establishments, each working at a small rate of profit, to cut their prices very fine—so fine, indeed, as to be able to considerably undersell private chemists trading on their own responsibility. Of course, it is necessary to employ qualified pharmacists as dispensers, but these are generally youths who have recently passed their examinations and who are glad to gain experience of business even at a small salary. But besides ordinary dispensing work a large business is done in the ordinary toilet articles that are sold by chemists, and in some cases additional attractions are added to create a *clientele* and make the shops known. The private pharmacist finds his legitimate business very much cut into by the large concerns, and many bitter complaints are made by them. There is no doubt that all pharmacy legislation is founded on the principle of individual responsibility, the Acts not contemplating any other position than that of the proprietor of the business being the active and responsible member of it, and this being so they are framed so that high, and justly high, standards of knowledge and conduct are demanded of the chemist who seeks to trade. To reimburse himself for his professional attainments and the cost of their acquirement the chemist has in the past been in the habit of charging his customers such prices as he could reasonably attach to his medicines, having regard to the skill required in their compounding. The price of a mixture is justly higher than the price of the bottle, cork, and drugs used, because of the essence of brains with which it is flavoured. If the chemist has to cut his profit the first thing that will go will be the brains, and the pharmaceutical profession, if it does not offer the prospect of a reasonable competency in the future, will attract men of a lower and lower type. As a whole, one is justly proud of the modern dispensing chemist, and the public owe him a great, though unacknowledged, debt. Doctor and public alike will suffer if a lower standard of individual is introduced in his place.

PERSONAL.

H.R.H. THE PRINCE OF WALES has kindly promised to honour the President and Fellows of the Royal Medico-Chirurgical Society with his presence at the Centenary Banquet in the Hotel Cecil, on Monday, May 22nd, when a large company is expected to meet this distinguished guest.

COLONEL F. HOWARD, London Recruiting District Medical Staff, has been appointed president of the Medical Board which is to examine Militia and Imperial Yeomanry candidates for commissions in the Regular forces.

THE Jacksonian Prize has been awarded by the Council of the Royal College of Surgeons of England to Mr. Herbert Paterson, M.A., M.B., F.R.C.S., Assistant Surgeon to the London Temperance Hospital, for his essay on "The Diagnosis and Treatment of Such Affections of the Stomach as are Amenable to Direct Surgical Interference."

DR. HADDON will resume his lectures on "Ethnology" at the London School of Economics on Friday, May 5th, at 3 p.m.

DR. R. W. LESLIE, of Belfast, has issued an address to the members of Convocation of the Royal University of Ireland as a candidate for a vacancy in the Senate caused by the resignation of Mr. Thomas Sinclair, F.R.C.S., Professor of Surgery, Queen University, Belfast.

THE Council of the University College, London, have appointed Sir Thomas Barlow, Bt., K.C.V.O., to the Holme chair of Clinical Medicine, vacant through the resignation of Professor F. T. Roberts.

MR. GEORGE ALEXANDER has kindly promised to give a *matinée* after Easter in aid of the Western Skin Hospital, Great Portland Street, of which the Hon. Harry Lawson, M.P., is treasurer. The Hospital is one of the very first established in the kingdom for special practice.

MR. LESLIE J. STEWART has sent a cheque for £400 to the North-Eastern Hospital for Children, Hackney Road, on account of the proceeds of the recent *matinée* in aid of the hospital at the Hackney Empire Music Hall.

LADY CURZON OF KEDLESTON has intimated to the Lieutenant-Governor of the Punjab that Europeans and Indians injured in the earthquake are to be treated in hospital as her guests.

THE late Mrs. Jane Begley, widow of Dr. William Chapman Begley, M.R.C.S., has bequeathed a sum of £20 per annum to the College of Surgeons for the purpose of founding a studentship in surgery and anatomy. The council expressed their willingness to take steps with a view to giving effect to Mrs. Begley's wishes.

THE brevet rank of Lieutenant-Colonel has been conferred upon Major William Boag Leishman, M.B., R.A.M.C., Professor of Pathology at the Royal Army Medical College, in recognition of his services and the distinction attained by him in original investigation and research.

DR. CHARLES BOLTON has been appointed by the Council Assistant Physician to the University College Hospital.

MISS ADA CROSSLEY, the famous Australian contralto, was married last week at Marylebone Church to Mr. Francis F. Muecke, M.B., who, though now for the moment a doctor at the London Hospital, is himself an Australian. The popular singer is a daughter of the late Mr. Edward Wallis Crossley, of Melbourne, and a

niece of the late Mr. John T. Crossley, Q.C. Mr. Muecke is a son of the Hon. H. C. E. Muecke, of Adelaide.

THE Birmingham Corps, St. John's Ambulance Brigade, assembled at the headquarters last week to take leave and present a handsome testimonial to Dr. Blakeney, the hon. surgeon of the division, who is leaving that city.

LAST week, Dr. Wolferston Thomas sailed for Manoa in connection with the second Yellow Fever Expedition sent by the Liverpool School of Tropical Medicine to South America. Dr. Antol Breinl will leave shortly for the same place.

DR. JOHN LINTON, of George Square, Edinburgh, who is retiring from practice after forty-six years in that city, was on Tuesday last presented with a large silver rose-bowl and a cheque for 105 guineas, together with a silver tea-service for Mrs. Linton and diamond and pearl brooches for the two Misses Linton. A large number of friends and patients subscribed to the testimonial.

DR. ADAM BEALEY, of St. Leonards-on-Sea, whose will was proved last week, has left gross estate valued at £32,286, including net personality sworn at £32,170.

DR. WILLIAM OSLER, Regius Professor of Medicine in the University of Oxford, has been elected an Honorary Fellow of the Royal College of Physicians, Ireland.

DR. E. J. M'WEENEY, Professor of Pathology and Bacteriology in the Catholic University, Dublin, was elected a Fellow of the Royal College of Physicians, Ireland, on the 7th inst.

At the annual election of President of the Royal College of Physicians of London on April 17th, Sir Richard Douglas Powell, Bart., was elected President for the forthcoming year.

NAVY MEDICAL APPOINTMENTS.

THE following were officially Gazetted on Friday last:—

Surgeons—C. H. Rock, to the rank of fleet surgeon, with seniority of May 15th, 1903; H. H. Gill, M.B., to rank of fleet-surgeon, with seniority of November 12th, 1903; and A. T. Wysard, to the rank of fleet surgeon, with seniority of May 13th, 1904.

Fleet Surgeons—J. L. Smith, M.B., to the Royal Marines, Chatham Division; W. E. Home, M.D., to the *Exmouth*, on recommissioning; and D. J. P. McNab, to the *Hannibal*, to date May 2nd.

Staff Surgeons—F. A. Capps, M.B., to the *Sapphire*, and H. S. Burniston, M.B., to the *Vernon*, to date May 2nd; and M. L. B. Rodd, to Plymouth Hospital, to date May 8th.

Surgeons—J. K. Raymond, M.B., and J. Verdon, to the Royal Marines, Chatham Division, and E. R. L. Thomas, to the *Exmouth*, on recommissioning, to date May 2nd.

ROYAL ARMY MEDICAL CORPS.

LIEUTENANT-COLONEL J. HOYSTD, Army Medical Staff (retired), is to proceed to Derby for duty. Lieutenant C. R. Tichborne, R.A.M.C. (Militia), assumes medical charge of troops and Non-Dieted Hospital, Kildare. Major F. W. Begbie is appointed Secretary and Registrar of the Military Hospital at Millbank. Captain A. M. MacLaughlin is posted to Belfast for duty.

Conjoint Examinations in Ireland.

CANDIDATES have passed the Second Professional Examination as undernoted:—

M. H. O'Sullivan (with Honours), S. Blake, W. Bomford, J. Ellenbogen, G. S. Levis, A. E. S. Martin, G. W. Stanley, E. Waide.

The following have completed the Examination:—
B. Foley, T. C. Casey, T. Fehilly, G. J. M. Martin, D. Sheehan.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

GLASGOW.

DEVELOPMENT OF SANITATION DURING THE NINETEENTH CENTURY.—The last of the Centenary lectures of the Royal Philosophical Society, Glasgow, was delivered on the 5th inst. by Dr. A. K. Chalmers, Medical Officer of Health for Glasgow, the subject being "Development of Sanitation during the Nineteenth Century." The author said that during the nineteenth century a great change had taken place in the general attitude towards disease. It was formerly regarded only as a misfortune to the individual, but it had come to be recognised as having a wider range, affecting the health of the nation. To-day it seemed to him there was a danger of sanitation being regarded too much from a conventional point of view, and that the problem, as it had appealed to the originators, might thereby suffer. He also thought that there was a great need for some means of supervising the different branches of local administration and so gather the various forces together and prevent energies being scattered and wasted. In illustration, he showed how, in Glasgow, educational, poor-law, and sanitary administration each performed duties which had reference to the benefit of the whole. The districts of these branches were placed irrespective of each other, and though it would not be necessary to have all within the same boundaries, still it would be well to be able to adjust the knowledge obtained from any subdivisions of sanitation to some larger districts—*e.g.*, poor-law or education. By this co-operation of the different branches many subjects might be discussed and acted upon, such as the following:—(1) Relation of pauperism to insanitary areas; (2) of neglected school-children to both; (3) of crime to both poverty and insanitation; (4) of insanity to the prevalence of particular diseases. The inquiries into the poor-law relief and causes of poverty during the nineteenth century had given birth to sanitary administration. It was not difficult to find a reason for this out-growth, as a great cause of poverty was disease, and, therefore, if disease were prevented, then the work of preventing poverty would be considerably lightened. He thought, however, that the real basis upon which sanitary science was founded was not so much a medical as a social and political one. He then gave an historical description of the development of sanitary science during the nineteenth century, and said that the finger of warning was pointing us towards the population of the slums and the jail—*i.e.*, the parasites of society, and he thought all branches—educational, poor-law and sanitary—should combine to study the influences at work which produced such effects. In the discussion which followed the reading of Dr. Chalmers' paper, Dr. Ebenezer Duncan referred to the advances made in sanitary science during the last forty years, or the period dating from his student days, emphasising the good work done by the late Dr. Fergus, Sir Wm. T. Gairdner, who is still with us, and the late Dr. Russell, Dr. Chalmers' predecessor as Medical Officer of Health for the City. Dr. Brownlie, Medical Superintendent of Belvidere Hospital; Dr. J. C. McVail, Medical Officer of Health for Dumbartonshire; Mr. Motion, Inspector of Poor; and the chairman, Dr. Murray, also took part in the discussion. A hearty vote of thanks was accorded Dr. Chalmers for his interesting and suggestive paper.

COMPRESSED AIR IN THE TREATMENT OF DISEASE.—A special meeting of the Southern Medical Society was held on the evening of Thursday, 13 inst., when Dr. Duncan exhibited and demonstrated to a large number of members the use of a compressed air chamber fitted up for the treatment of disease in a variety of forms. It is the first of fifty, or thereabouts, in use all over the country to be fitted up in Scotland. It consists of a large circular chamber formed of steel, capable of accommodating three or four patients comfortably. Within the chamber there is an electrical appliance,

by means of which ozoné can be generated when required. Dr. Ebenezer Duncan stated that this line of treatment had proved extremely useful in certain respiratory affections. In asthma the severe paroxysms of breathlessness are speedily relieved. In bronchitis and in all conditions where there was a tendency to engorgement of the right side of the heart, benefit followed, as an emptying of the veins and a rapid filling of the arteries was observable. Of course, in cases with a tendency to atheroma there would be a risk of the distension of the vessels leading to rupture, hence care is necessary in the selection of suitable cases. Then, again, cases of anæmia have improved and others been cured by means of this treatment. Several members of the Society entered the chamber, where they were imprisoned for thirty or forty minutes. The only feeling of discomfort was, in one case, slight headache, which was of a transitory character. The cost of the chamber with the driving power is considerable, and as it is only in the experimental stage in Glasgow, it requires time to prove how far it may be successful as a therapeutic agent. It is certainly substantial enough. Dr. Duncan is very sanguine of its success from his knowledge of its use, and the satisfactory results obtained in other countries.

BELFAST.

THE GENERAL MEDICAL COUNCIL AND THE DIRECT REPRESENTATION OF IRELAND.—This matter has come very much to the front in Belfast in the last few days, owing to the reading of a letter from Dr. Leonard Kidd to his fellow-members of the Ulster Medical Society at a meeting last week. The figures laid before the meeting are certainly striking, showing as they do that in England and Scotland the majority of the members of the General Medical Council are from the provinces, while in Ireland every one of the seven members comes from the Metropolis. Though the members refused to commit themselves to any particular candidate at such an early stage, it was plain that the feeling of the meeting was in favour of a provincial candidate, and after the meeting a number of members signed a requisition to the secretary to call a special meeting to consider the whole question. It is acknowledged that it is unfortunate that it should be necessary to oppose a man who has done such excellent work as Sir William Thompson has done, but since he is the only direct representative, there is no choice in the matter. It is pointed out, moreover, that Sir William Thompson can easily obtain a seat on the Council as the representative of one of the Corporations with which he is connected, should he be displaced. At any rate, whatever may be the outcome, the fight promises to be a lively one.

ULSTER EYE, EAR AND THROAT HOSPITAL.—The annual meeting of this charity was held last week, when special reference was made by various speakers to the great loss it had sustained by the death, since the last annual meeting, of their surgeon, Dr. McKeown. The medical report was read by his successor, Dr. W. M. Killen. During the year there were 1,528 new cases in the extern department, and 273 patients were admitted to the wards. The report also made special mention of the new giant electro-magnet and of the X-ray apparatus lately fitted up. Anæsthetics were administered in 130 cases.

DR. H. O'NEILL'S PARLIAMENTARY CANDIDATURE.—Dr. O'Neill, formerly a surgeon to the Belfast Royal Hospital, and at present a member of the Corporation, a Barrister-at-Law, and a Justice of the Peace and High Sheriff for Belfast, has appeared in another role—that of candidate for parliamentary honours. He has been selected to contest South Belfast for the Belfast Conservative Association, which means the orthodox Orange body, against the present member, Mr. Sloan, who, as an independent Orangeman, won the seat from the orthodox candidate at the last election. As Dr. O'Neill has generally been looked upon by his fellow-practitioners as a pronounced Radical and a strong Free-trader, his election address is looked forward to with considerable interest. A good many years ago, when Dr.

O'Neill was merely a candidate for municipal honour Mr. John Fagan, then his colleague on the staff of the old Royal Hospital, and now Inspector of Industrial Schools, had occasion to propose his health at a dinner of the Ulster Medical Society. He said that he was reminded of the motto put on the front of his engine by an engine-driver of one of the first trains on the Canadian Pacific Railway leaving the east—"Vancouver or bust," and he suggested that Dr. O'Neill had started for Vancouver. His prophecy seems to be turning out true, but the issue remains with the electors for the present.

Correspondence.

THE TEACHING OF HYGIENE AND TEMPERANCE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Sir Thomas Barlow, in his admirable address at the recent Medical Conference, stated that the present relation of the medical profession to alcohol was that of the open mind. May it ever be so! The question of the action of alcohol in the economy is one of national importance, and a knowledge of the elementary laws of hygiene essential to the well-being of the people. I make bold to state it does not matter what opinion we may hold concerning our individual abstinence from or moderation in the use of alcoholic beverages, for we as a profession are at one in believing that every child in our empire should be taught the principles of hygiene and temperance in their early and impressionable years. They will then, when they reach the time to choose for themselves in the matter of alcoholic indulgence, be able to make their choice deliberately, with some amount of knowledge of its possible effects. Even Dr. Sers will admit this, for he was one of the 15,000 who signed the petition to the Board of Education, and the fact that he is not a total abstainer adds to the value of his signature. We do not wish to draw the red-herring of total abstinence across the well-set course of education in these essential matters. Let the children be instructed and let them afterwards make their choice. In the remarks which I was permitted to make at the Conference last month, I urged the desirability that all medical students should receive such teaching concerning alcohol and its bearings as would prepare them to deal with the hundred-and-one circumstances in which alcohol will meet them in their professional career. Dr. Kelynack's letter in a previous issue was opportune, and allows me to say that I believe that this teaching might be given in a short series of lectures in every medical school, delivered once in each academic year. Or, if this were not feasible, then, so far as London is concerned, by a series of lectures at some central place, possibly under the auspices of the University of London. Attendance at either series should be wholly voluntary, but if the lecturer was a good teacher, and the matter was sound, students would attend, as is evidenced by the fact that at such a lecture recently in one of our metropolitan schools over fifty were present. Apologising for thus trespassing upon your space,

I am, sir, yours truly,

W. MCADAM ECCLES.

London, W., April 14th, 1905.

Obituary.

DAVID STEELE MOON, L.R.C.P. & S. EDIN.

THE death occurred last week of Mr. Steele Moon, one of Dundee's best known medical men. He had been laid aside by illness for a considerable time past, and his death was not unexpected. He attended classes at the Andersonian University, Glasgow, and at Edinburgh received the double qualification of L.R.C.P., and S. in 1869. He held the position of resident surgeon in Glasgow Royal Infirmary, and became house-surgeon and general medical superintendent to Dundee Infirmary, which post he held for ten years, afterwards entering into private practice.

FRANCIS WILLIAM GRANT, M.D., M.B., C.M. EDIN.

WE regret to record the death at Droitwich of Surgeon-Major Francis William Grant. He was forty-three years of age, and was surgeon-major of the Royal Garrison Artillery Volunteers. He was attached to the Royal Artillery in South Africa, and received the medal and three clasps, but was attacked by dysentery and invalided home. Major Grant had held successively several public appointments before going to the war, and was known as an able contributor to the leading medical journals.

DAVID SMITH, M.R.C.S. ENG., M.D. ST. AND.

GLASGOW has lost one of her oldest practitioners in the person of Dr. David Smith, who recently passed away in his 70th year. He studied at the Universities of Glasgow and St. Andrews, where he had a distinguished career. After graduation he was appointed demonstrator and assistant to Dr. Mackenzie, a post which he held for seven years, afterwards starting for himself in the East End of Glasgow, where he soon had a large practice. After some years he abandoned general practice for ophthalmic work. He was much esteemed by everyone for his professional ability and for his uprightness and candour. He was a member of the Church of Scotland, and for many years an elder. He leaves behind him a widow, a son, and a daughter.

Literature.

BAIN'S PRACTICE OF MEDICINE. (a)

THIS is a good text-book. Its general plan is sound. Each of its sections—as for example: alimentary canal, skin, nervous system—opens with a concise account of the anatomy and physiology of the region concerned. The result is a far more complete and adequate treatment of the subject than is contained in the ordinary text-book of medical practice. The space devoted to particular maladies is necessarily limited in a volume that is confined to 1,000 pages. Condensation, therefore, in some places leads to a want of emphasis in others. Under delirium tremens, for instance, the general condemnation of alcohol and of opium, and the absolute salvation of sleep are hardly sufficiently insisted upon; while no mention is made of the occasional confusion of acute alcoholism with acute mania, an error we have seen perpetrated in large modern infirmaries. For most of the articles we have nothing but praise. That upon hyphoid fever (*sic*) may be taken as an example. It is adequate and interesting, and contains an illustration of the agglutination test, nearly twenty pages are devoted to that disease. The section on diseases of the nervous system is clearly and accurately written by Dr. Risien Russell. Among other writers are Professors Arthur Robinson, T. G. Brodie, Sydney Martin, Rose Bradford, J. Dixon Mann. Dr. Bain himself contributes a section on diseases of the thyroid, suprarenal and thymus glands, and another on gout. The section on skin is ably dealt with by Dr. Arthur Whitefield. His position, however, with regard to the skin as an organ of excretion in relation to cutaneous disease is not clear. He admits that the skin undoubtedly plays a part in the elimination of a number of drugs, as copaiba. He dismisses the elimination of micro-organisms as doubtful, and makes no mention of toxic rashes. But under erythema he gives as causes, drugs, toxins existing in the body, poisons usually shut off from the circulation (*e.g.*, enema rash), auto-toxæmias (uræmia, &c.), and "acutal presence of the organism in the eruption," &c. This paragraph precisely repeats the general law advanced fifteen years ago under the name of excretory irritation, in which many symptomatic rashes were attributed to the excretion or attempted excretion *via* skin of drugs, micro-organisms and their products, and certain disease poisons, as gout. If Dr. Whitefield adopts that theory it should surely be acknowledged. Returning to Dr. Bain's work we can

cordially recommend it to all medical practitioners as a mine of useful, well-arranged and up-to-date information.

THE MEDICAL ANNUAL, 1905. (a)

"THE Medical Annual for 1905" differs slightly in form from the volumes with which we have all grown familiar, in that the size of its page has been somewhat increased, in order to enable its contents to be included without further adding to the thickness of the book. As the editor states in his short preface, the change has long been contemplated, and at last he has been compelled to bow to the inevitable and this year to adopt it. He need not, however, we think make any apologies for the alteration, for the result is most satisfactory and the book in general appearance looks neater than its predecessors, with which, by the way, it is identical in all but size.

We at first set out with the intention of rapidly running through the book, but found the opening sections so interesting that we ended by carefully reading through almost the entire volume. Every page appears to have been studied with care before it left the hands of the compilers, and it is difficult to think of any general medical subject that has not been dealt with more or less fully. The only suggestion that we would make is, that in future it would be well if the editor or writer would express a little more frequently an opinion on the matters referred to. As it is, a busy medical man unable to keep well informed on every matter may turn to this volume for assistance and also for guidance; full assistance in the way of the latest information he will undoubtedly get, but in rather too many sections he is left to form his own opinion concerning the value of the information received. This of course, is no new criticism on the book and consequently we must suppose that the editor considers such guidance unnecessary, but we believe that the value of the volume would be enormously increased by the addition suggested.

As in previous numbers, the first portion of the book is devoted to an account of the most important therapeutic advances of the year. This portion was compiled by the able pens of Professor Stockmann and his assistant, Dr. Charteris, and includes a brief account of current opinions regarding serum and organotherapy. As the authors state in their introductory remarks, there has been no striking therapeutical discovery during 1904, but on all sides there has been some general advance, mostly indeed in the direction of the introduction of new remedies, but also in discovering new indications for, and in more exactly defining the actions of well-known remedies. We notice that considerable attention has been paid to the papers of MM. Widal and Javal, on the relation of chlorides to excretion in renal disease, and some suggested chloride-free diets are given. These should prove of much value not only as they stand, but also as a basis for making out similar dietaries. Following on the section dealing with general therapeutics come short accounts of intravenous and electro-therapeutics by Hutchison and Macintyre respectively. The first of these is especially necessary at this time, when we are being daily inundated with papers relating to marvellous cures of phthisis and of septic conditions by the injection into a vein of a little formalin or other antiseptic. We are glad to see that Hutchison points out the dangers attendant on such medication and expresses a scientific scepticism regarding its value. Next comes the general review of medical and surgical progress during 1904. This constitutes 500 out of about 700 pages, and therefore forms the main mass of the book. It would be quite impossible to refer here to any of the enormous number of subjects dealt with in it, but we may repeat that we consider the work to be very thoroughly and well done, and that no practising medical man can fail to find much to aid him in the book. The inclusion of some plates adds much to the general

(a) "A Text Book of Medical Practice." By William Bain, M.D. Darh., M.B.C.P. Lond., 1904. London: Longmans, Green and Co.

(a) "The Medical Annual, 1905." Bristol: John Wright and Co. London: Simpkin, Marshall, Hamilton Kent and Co.

appearance, and the fifteen stereograms from Neisser's atlas forms a useful series representing various eye diseases. Lastly we may say that not only the index but also the arrangement in alphabetical order makes reference easy, and that the lists of private asylums, sanatoria and surgical homes will prove a convenience to many.

Literary Notes and Gossip.

A MANUAL of Midwifery by Henry Jellett, M.D., will be published in a few days by Messrs. Bailliere, Tindall and Cox in their well-known University Series. Having seen an "advance" copy we can announce that it appears to be a most comprehensive work, whilst the illustrations are exceptionally fine and numerous. Dr. Jellett acknowledges in his preface having received the help in writing it of Dr. Moorhead, who contributes the chapters on obstetrical anatomy and embryology, of Dr. Drury who contributes the chapters on organic, functional, and specific infectious disease in pregnancy; of Dr. Rowlette, who contributes the sections on the ætiology and pathology of the "Surgical Fevers of the Puerperium," and of Dr. Dawson, who contributes the sections on the insanities of reproduction.

THE appearance of the sixth section of Toldt's "Atlas of Human Anatomy," completes this magnificent work, which now contains 985 pages and 1,505 illustrations, and deals with every phase of human anatomy. The section before us is composed of two parts, the first of which deals with the subject of neurology, the second with the organs of the senses. It is the largest section of the book, and contains particularly fine illustrations. The publishers are to be heartily congratulated on the production of this important work, and on the manner in which it has been carried out by the translator, to whose work we have already referred in a previous notice.

"SURFACE ANATOMY," by Dr. Moorhead, of Dublin, just received, is likely to become popular with students. It gives a clear and accurate description of the surface anatomy of the human body. A sound knowledge of these landmarks is as essential for the physician and for the surgeon, as for the student. Anything like adequate information of the kind, however, comes comparatively late in a few individual cases, owing chiefly no doubt to a defect in systematic education. So far as we have tested the facts and illustrations in Dr. Moorhead's book, they are trustworthy, and grouped together in an effective way, but we purpose reviewing the work in detail later on.

ALTHOUGH the Milroy Lectures for 1904 ("Deaths in Childbed," by W. Williams, M.D., D.P.H.Oxon.) have already received the usual wide publicity afforded by the columns of the medical press, some will doubtless be glad to have them in this reprinted book form. (London: H. K. Lewis.) Dealing with the subject of child-bed mortality mainly from the point of view of preventive medicine, the appearance of the volume is especially opportune at a time when so many local authorities are beginning to set their houses in order by appointing medical inspectors and supervisors of midwives under the new act, and we are sure that the information these pages contain will be simply invaluable to the occupants of such posts, as well as to all in whose hands public health administration is placed, and all who are interested in the development of what Dr. Clouston has christened "a health conscience."

We have again to congratulate the publication committee of the Society for the Study of Diseases in Children on the appearance of their fourth volume of annual reports, which is, like its predecessors, replete with interesting records in the domain of pædiatrics. Among specially noteworthy papers may be mentioned those of Cautley and Dent on congenital hypertrophy

of the pylorus, a topic which is exciting very general interest at present, and the best means of treating which is still *sub judice*, that on congenital word blindness by Sydney Stephenson, and that on the subject of delayed chloroform poisoning by Stiles and Macdonald, who do not a little to elucidate a matter which in this country, at least, has been chiefly studied by those connected with children's hospitals. In the rest of the articles and clinical records so many remarkable and instructive cases are described that no one interested in the diseases of children—and who is not—ought to delay reading this volume.

UNDER the modest title "The Story of an East London Hospital" (Macmillan and Co.) this little volume contains a tale of enthralling interest—the account of the life work of one of medicine's true heroes, the late Dr. Heckford, of whom the onlooker, standing in the Shadwell Children's Hospital may well say, "*si monumentum quaeris, circumspice*," for to his exertions this institution owes its existence. The account of his strenuous life as told by his widow discloses the self-sacrificing devotion of her husband, in spite of a reticence of narration which compels our admiration and unintentionally reveals how greatly Dr. Heckford's cherished schemes were seconded and how ably his work was assisted by his helpmate. The volume has been re-issued after twenty years in the hope that the public may learn the needs of the East London Hospital, and we cannot imagine that anyone into whose hands it falls, but will feel it a privilege to help to carry on the work for which Heckford gave his life. Apart from this, however, the literary worth of the volume may be judged from the fact that besides Charles Dickens' well-known paper on the Shadwell Hospital, written in 1868, it contains Mr. R. L. Stevenson's "Admatum," Mr. W. E. Henley's "Hospital Sketches," a ballad by Mr. Andrew Lang, and a charming idyll by Miss May Kendall—a choice and worthy setting for the story of a good man's life.

Laboratory Notes.

NEW PREPARATIONS.

THE ALLENBURY'S DIET.

THE Allenbury's Diet represents an attempt on the part of Messrs. Allen and Hanbury to supply, in the form of a simple powder, all those nutritive bodies that are usually obtained by adding the ordinary infant cereal foods to milk. As such it has a sphere of usefulness which the ordinary foods cannot fill. To travellers and to dwellers in foreign climates where good milk is difficult to obtain, Allenbury's Diet should prove very acceptable. Prepared as it is from whole wheat, predigested during manufacture, and from milk rich in cream, the diet contains all that is needed to sustain and nourish the human organism; the facility with which it can be got ready for use—merely by adding boiling water—is a unique recommendation. "The Allenbury's Diet" is the title by which the makers expect this preparation to become known, as much confusion has arisen from its heretofore association with their other well-known series of foods. We have found the diet well liked by patients and it has a great advantage in not being sweetened. We think, however, the quantities recommended are somewhat smaller than those which make the most palatable mixture.

ELIXIR GLYCEROPHATES COMP.

In their Elixir Glycerophates Comp., Messrs. William Warner and Co. have succeeded in producing a very pleasant bitter tonic compounded of the glycerophates of calcium, sodium, iron, manganese, quinine and strychnine. We have tried this preparation and have found it appreciated by those for whom these valuable drugs are indicated.

ELIXIR GLYCEROPHATES.

Another elixir of the glycerophates—this time the glycerophosphates of lime and soda—is prepared by the same firm under the title of Elixir Glycerophates,

Lime and Soda. It is an elegant combination of the constituents named, and is likely to be of special use in the malnutrition diseases of infants and children.

DIOXYGEN.

The uses of nascent oxygen in the treatment of wounds and septic processes are too well known to need description. Dioxxygen is a preparation of hydrogen peroxide, manufactured by the Oakland Chemical Company, and adapted for internal and external use. As a deodoriser and as a mouth-wash, dioxxygen is likely to be much in demand, and encouraging reports are to hand of its use as an internal antiseptic. The administration of hydrogen peroxide by mouth is always free from the danger of poisoning that accompany the use of so many otherwise desirable bactericidal substances.

NEW TABLOIDS.

Messrs. Burroughs and Wellcome are never satisfied with past victories, and are always to the fore with "tabloid" preparations of new drugs or new combinations of old drugs. Three of their tabloids are before us as "Tabloid Veronal," "Tabloid Three Valerianates," and "Tabloid Zinc Valerianate." With veronal coming so much into favour as an hypnotic, there are many who will be glad to have the cachet of Messrs. Burroughs and Wellcome's name on the preparation they prescribe, besides enjoying the convenience of having compressed drugs always to hand in appropriate doses. The three valerianates are those of quinine, iron and zinc in doses of one grain each. This tabloid, as well as that of zinc valerianate alone, is sugar-coated, and when valerian is used for its internal action rather than its moral effect the value of this method of concealing its taste is excellent. Although valerian in solution may be prescribed for the hysterical servant-girl, most medical men have discovered that they consult their own interests best by giving it in tabloid form to the mistress of the house

Medical News.

Society for the Relief of Widows and Orphans of Medical Men.

At the Quarterly Court of the Directors of the above Society, held on Wednesday last, April 12th, the president, Mr. Christopher Heath, F.R.C.S., in the chair, three new members were elected. The treasurer announced that a legacy of £250, duty-free, had been received from the executors of the late Mrs. Jane Begley. One new widow and one orphan were granted relief at the rates of £50 and £12 per annum respectively. The sum of £1,293 had been paid in half-yearly grants in January to the annuitants of the charity. Fifty-three widows and seventeen orphans are now on the books of the Society. The date for the annual general meeting was fixed for Monday, May 22nd, at 5 p.m., at the offices of the Society.

Royal College of Surgeons of England.

At a quarterly meeting of the Council, held at the College on Thursday last, the 13th inst., Mr. John Tweedy, president, in the chair, the following candidates (having passed the required examinations and conformed to the bye-laws) were admitted members of the College:—Sidney Herbert Daukes (Eynsford, Kent), John Robert Irwin (Endsleigh Gardens), David Morgan Jones (Rainham), and Lewis Thomas (Nova Scotia, Canada). A diploma for the Licence in Dental Surgery was issued to Allan Angell (East Dulwich).

The Jacksonian prize for the year 1904 was awarded to Mr. Herbert J. Paterson, F.R.C.S., M.B., B.C. Cantab. of Upper Wimpole Street, for his essay on "The Diagnosis and Treatment of such Affections of the Stomach as are Amenable to Direct Surgical Interference." The following was selected as the subject for the Jacksonian prize competition for the year 1906: "The Diagnosis and Treatment of those Diseases and Morbid Growths of the Vertebral Column, Spinal Cord and Canal, which are amenable to Surgical Operations.

A report was received from the committee appointed to consider the practicability of the institution by the College of a school for the teaching of the early and intermediate subjects of the medical curriculum and of advanced pathology. The report stated that the committee had under consideration a scheme for a school of the kind proposed, and an estimate of its probable cost. From this estimate it appeared that even if the school were a success, the College would have to meet an annual deficit of £3,400. As this sum could not be provided out of the College funds, the committee reported that, in their opinion, it is impracticable for the College to institute such a school without adequate endowment. The Council concurred with the view expressed by the committee.

Mr. Henry T. Butlin, F.R.C.S., was re-elected a representative of the College in the Senate of the University of London.

A New "Peace" Society among Medical Men.

OUR Special Continental Correspondent writes us that a new peace society, the members of which are exclusively medical men, has been formed in Paris, under the title of L'Association Medicale Internationale Contre la Guerre. Its present headquarters are at 25, Rue des Mathurin, the residence of Dr. Riviere, the originator of the society. Hundreds of medical men in all parts of the Continent have given their approval to the project. A Peace Congress, representing the medical faculty all the world over, will be held in 1907.

St. Thomas's Medical School.

THE following prizes for the Winter Session 1904-5 have been awarded: Second year's students:—W. B. Johnson, the William Tite Scholarship, £25. Third year's students: R. W. Rix, the Musgrove Scholarship, £35; J. A. Clarke, college prize, £20; H. A. H. Robson, college prize, £10. Fifth year's students: C. Ll. Morgan (medicine), £10; H. T. Gray (surgery), £10; J. M. Wyatt (midwifery and diseases of women), £10; C. J. Langley (pathology), the Hadden Prize, £10; H. T. Gray and L. E. C. Norbury (pharmacology), £5 each; L. E. C. Norbury (forensic medicine and insanity) £10; G. J. Langley (public health), £10. The Mead Medal and the Seymour-Graves-Toller Prize for proficiency in practical medicine, pathology, and hygiene were awarded to G. J. Langley; the Wainwright Prize to H. R. Dean; the Cheselden Medal or proficiency in surgery and surgical anatomy to L. E. C. Norbury.

A Recent Will.

MR. LUTHER HOLDEN, of Pinetoft, Ipswich, late President of the Royal College of Surgeons, who died on February 6th, bequeathed to St. Bartholomew's Hospital, £3,000 for a scholarship in surgery to be called the "Luther Holden Scholarship," and £500 towards the rebuilding fund, and £1,000 to the Foundling Hospital. His freehold residence, with the furniture, &c., and £10,000 is to be held in trust for his wife, Mrs. Frances Holden, for life, and then such property is to be sold and the proceeds and the sum of £10,000 divided between St. Bartholomew's Hospital for its Samaritan Fund and the Foundling Hospital for its Benevolent Fund. The value of the estate is £110,289, of which £99,155 is net personalty.

Irish Medical Association and Direct Representation.

At a meeting of the Fermanagh Branch on April 10th last, Dr. Graham, of Irvinestown in the chair, it was proposed by Dr. Betty, seconded by Dr. Thompson, and passed—"That this Branch approves of the principle of appointing a provincial general practitioner as Direct Representative for Ireland on the General Medical Council."

DR. M. J. NOLAN, resident medical superintendent of Down Lunatic Asylum, was presented on Saturday last with a congratulatory address and a gold watch in recognition of his invaluable services in the improvement and re-organisation of that institution. Mrs. Nolan was also the recipient of an autograph silver salver.

Notices to Correspondents, Short Letters, &c.

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

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 re-forwarding 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.

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.

PHYSICS.—We intend drawing attention to the matter in an early issue.

L.R.C.P.—The Dean of the College will give the information required.

F. D. (Yorkshire).—Women can take out the licences of the Irish Apothecaries' Hall on conforming with the regulations which are almost identical with the other licensing bodies. The Assistants' Degree is also open to women after two years in compounding.

GYNÆCOLOGIST.—The largest works are in French or German, but we understand that Dr. Jellett of Dublin, has now an exhaustive volume on Obstetrics now in the hands of the printer.

DR. H. (Missenden).—Tobacco smoke contains a variable proportion of carbon monoxide (1 to 7 per cent.), but the bad effects of inhaling the fumes of cigarettes are probably due less to this source of blood-in-toxicant than to the directly irritating effects of the pyrogenous constituent of the smoke.

EASTER HOLIDAY.—Try Biarritz. The weather there at this season is capital. Abundant amusements, good golf links, and the hotels reasonable.

J. W. S.—We have no objection to your making use of the article provided it is suitably acknowledged.

A SPURIOUS "DIRECTORY."

An important letter from Dr. Kinkead, Vice-President of the Irish Medical Association, in answer to Dr. E. J. O'Connell and dealing with the responsibility of the Irish Medical Association for the so-called Directory which has been recently published, will be found by our Irish readers in the Poor-law Supplement of the present issue.

DR. S. (Leeds).—The paper you mention (The Code of Hammurabi) was written about 2,250 B.C., and has been translated by Prof. Harper of New York. It deals with laws relating to ophthalmologists, the economic value of the eyes of freemen, slaves and oxen, and decrees that a surgeon saving an eye is to be rewarded as one saving a life.

THE LESSER EVIL.

Patient: "You have no idea, doctor, what inconvenience I suffer with my hands and feet."

Doctor: "Yes but just think what inconvenience you would suffer without them!"

Oxon.—The Subject to which you drew attention is of great interest, but not to the medical profession.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, APRIL 19th.

ROYAL MICROSCOPICAL SOCIETY (90 Hanover Square, W.).—8 p.m. Exhibition of Pond Life. Paper:—Mr. A. E. Conrady: On the Application of the Undulatory Theory to Optical Problems.

ROYAL METEOROLOGICAL SOCIETY (Institution of Civil Engineers, Great George Street, Westminster, S.W.).—7.30 p.m. Papers: Mr. W. H. Dines: An Account of the Observations at Crinan in 1904 and Description of a New Meteorograph for Use with Kites.—Dr. H. E. Mill: Rate of Fall of Rain at Seathwaite.

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY (20 Hanover Square, W.).—6.30 p.m. Papers:—Dr. E. McIlure: The Climatology of the Sahara.—Dr. E. Felkin: Sea Voyages for Invalids.

MEDICAL GRADUATES' COLLEGE and **POLYCLINIC** (23 Chancery Street, W.C.).—4 p.m. Mr. H. Pinch: Clinique. (Surgical.) 5.15 p.m. Mr. H. L. Barnard: Gastric Surgery.

CENTRAL LONDON THROAT AND EAR HOSPITAL (Gray's Inn Road, W.C.).—5 p.m. Demonstration: Dr. Abercrombie: Nose.

Vacancies.

West Riding Asylum, Wakefield.—Junior Assistant Medical Officer. Salary £140 per annum, with apartments, board, washing, and attendance. Applications immediately to the Medical Director at the Asylum.

Devon County Asylum, Exminster.—Junior Assistant Medical Officer. Salary £125 per annum, with board, residence, and laundry. Applications to the Medical Superintendent.

Sunderland Borough Asylum, Ryhope.—Assistant Medical Officer. Salary £120 per annum. Applications immediately to the Medical Superintendent, The Asylum, Ryhope, Sunderland.

Assistant Medical Officer for County Asylum.—Salary £150 per annum. Applications to the Scholastic, Clerical, and Medical Assn., Ltd., 22 Craven Street, Strand, W.C.

National Hospital for the Relief and Cure of the Paralysed and Epileptic, Queen Square, Bloomsbury.—Resident Medical Officer. Salary £100 per annum, with board and residence. Applications to Godfrey H. Hamilton, Secretary.

Devonshire Hospital, Suxton, Derbyshire.—House Surgeon. Salary £100 per annum, with furnished apartments, board, and laundry. Applications to the Secretary.

Resident Medical Officer for Private Asylum.—Salary £200 per annum. Applications to the Scholastic, Clerical, and Medical Association, Limited, 22 Craven Street, Strand, W.C.

London Fever Hospital, Liverpool Road, N.—Assistant Resident Medical Officer. Salary £120 per annum, with board and lodging. Applications to the Secretary.

Bristol General Hospital.—Senior House Surgeon. Salary £130 per annum, with board, residence, &c. Applications to the Secretary.

St. Andrew's Hospital for Mental Diseases, Northampton.—Junior Assistant Medical Officer. Salary £20 per annum, with board, furnished rooms, and washing. Applications to the Medical Superintendent.

Nottingham General Hospital.—Assistant House Physician. Salary £100 per annum, with board, lodging, and washing. Applications to the Secretary.

Appointments.

FERGUSON, JOHN P., L.S.O.P. & S. Edin., L.F.P.S. Glasg. Medical Officer of Health for the Mitheron Rural District.

HISCOX, J. B., M.B., C.M. Edin., Certifying Surgeon under the Factory and Workshop Act for the Lewisham District of the county of London.

HUNT, A. W. D., M.R.C.S., L.R.C.P. Lond., Certifying Surgeon under the Factory and Workshop Act for the Obaford District of the county of Devon.

KETSER, CHARLES R., F.R.C.S. Eng., Assistant Surgeon to the Cancer Hospital, Fulham Road, S.W.

LETT, HUGH, M.B., Ch.B. Vict., F.R.C.S., Assistant Surgeon to the London Hospital.

MACKENZIE, F. S., M.B., Ch.B. Edin., House Surgeon to the County Hospital, York.

MAYOU, STEPHEN, F.R.C.S. Eng., Ophthalmic Surgeon to the Hospital for Epilepsy and Paralysis, Maida Vale, London, W.

MOOR, R. O., M.D. Oxon., M.R.C.P. Lond., Physician to the Out-patients at the Royal Waterloo Hospital.

PHELPS, G. A., M.R.C.S. Eng., L.S.A., Certifying Surgeon under the Factory and Workshop Act for the Walsall District of the county of Stafford.

Births.

MASON.—On April 15th, at 45 George Street, Portman Square, London, the wife of G. A. Mason, M.A., M.B., B.C. Cantab., of a son.

Marriages.

HUTTON-SMART.—On April 18th, in the University Chapel, Glasgow, William Kilpatrick Hutton, M.A., M.B., to Christiana Elder Symington, daughter of William Smart, LL.D.

Deaths.

BIGG.—On April 14th, at Salisbury House, Heaton, Newcastle-on-Tyne, Reginald Bigg, M.B., fourth son of the Rev. Charles Bigg, D.D., of Christ Church, Oxford.

DAVIDSON.—On April 14th, at Culross Park, Culross, Fife, Elizabeth Campbell, daughter of the late Arthur Campbell, of Cairnie, and widow of Dr. Robert Halkerton Davidson, Deputy-Inspector-General of Hospital of H.M. Indian Army.

GOLDSTEIN.—On April 12th, at Bournemouth, Harry Vivian Goldstein, M.B., B.Ch., late of Edinburgh, and Auckland, New Zealand, aged 28 years.

LADY TRAINED NURSE would be glad to hear of child requiring country home. Cottage in pretty country village. Bracing air. Individual attention. Highest references given in exchange.—MISS CALVERT, Whippsnade Common, near Dunstable, Beds.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXX.

WEDNESDAY, APRIL 26, 1905.

No. 17.

Original Communications.

SOME

ASPECTS OF RHEUMATISM. (a)

By ALEX. MORISON, M.D., F.R.C.P. LOND. & ED.
Physician to the Great Northern Central Hospital and to the
Children's Hospital, Paddington Green.

THE subject of rheumatism selected for discussion by this Society is an important one, being responsible in its acute form, according to the last report of the Registrar-General, for 2,875 deaths in England and Wales alone, and also, indirectly, for a large proportion of the 48,195 deaths registered as due to heart disease. Having had but short notice, I fear I cannot do justice to my theme, but shall endeavour to take a sufficiently wide view of the complaint so as to invite discussion on its many important aspects.

Those of us who parted from our Alma Mater in the North in the early seventies are in a position to recall important changes in opinion both as to the nature and treatment of the disease. To give any adequate account of these, in the necessarily short remarks which the time at my disposal compels me to make on this occasion, is not possible, but we can scarcely intelligently realise the present trend of opinion in this matter without a brief retrospect.

Before the period I have mentioned, although physicians were by no means satisfied with the explanations given of this widespread disorder, there was a general belief that the disease was autogenetic—that is, that it arose within the patient, and, beyond being favoured in its appearance by certain climatic conditions, could not be ascribed to any active extraneous cause. The autogenetic theory which ultimately, for a considerable period, became most prevalent was, that the generation of lactic acid in the muscular system under conditions of exhaustion was chiefly responsible for all the phenomena of the disease, even the endocarditis so frequently associated with it. Hence arose the almost universal custom of prescribing alkalis to neutralise this state, and the recognition of the importance of rest, in the midst of warm woollen clothing, as a therapeutic measure. "Six weeks and blankets," to use an expression frequently employed, was the favourite remedy of many wise physicians, and that, so far as the blankets and rest were concerned, it was a safe and rational line to take,

even if the rôle of the physician was a restricted one, cannot be doubted even now.

In 1876, the late Dr. T. J. Maclagan expounded the "miasmatic" theory of rheumatism, and arrived at the conclusion that, like the malarial infection, the cause of rheumatism was to be sought in an extraneous agent, which was most prevalent in swampy regions. I do not think modern bacteriological writers give Dr. Maclagan sufficient credit in this matter. "Paludal fever" on the puddle theory (for I suppose that familiar substantive really boasts a classical origin from *palus—paludis*) was forcibly enunciated by him, and led to his seeking the antidote beside the bane. The cinchona tree of the swamp indicated the willow by the water-course, and however erroneous in details we now know his theory to have been it contained not only the truth as we now regard it of an infective origin for the disease, but also by a happy accident the discovery of the value of salicin in the treatment of rheumatism. The co-operation of the mosquito and man in producing the active agent in malarial fever was of course unknown at that time, but the extraneous origin both of malaria and rheumatic fever remains, and the value of salicin in the latter disease has been no more impaired than has that of cinchona in ague. It will ever be the glory of Maclagan that his reasoning led to the employment of the one drug in rheumatism which has proved of real value. Those who have had experience of the results of the treatment of rheumatism before and after the use of salicin and the salicylates will never be shaken in their belief that, account for the results how you will, a new epoch was introduced in the treatment of rheumatism by Maclagan. Personally I have no sympathy with the attempts to belittle Maclagan's ratiocination in this matter. Even his bane and antidote theory is poetic, and life needs all the poetry we can put into it. For nearly twenty years little of much value was added to Maclagan's theory and practice, and, if our views as to the essential cause of rheumatism are now undergoing a change, salicin and the salicylates properly used still hold the field in the treatment of this disease.

I would suggest that the manner of using these drugs, so as to gain most benefit from them, might be usefully discussed. The mere relief of pain, and the recuperative quiet following the subsidence of articular agony, is a great point gained. But, I believe, salicin effects more than the relief of pain, great as that benefit is. The whole course of the disease is in many cases shortened thereby, and, when a case defies the therapeutic influence of these remedies and exhibits an ingravescent

(a) Article introducing a Discussion on Rheumatism, read before the Association of Medical Diplomates of Scotland, at the Medical Society's Rooms, London April 18th, 1906

deterioration—when a simple acute rheumatism becomes virulent or malignant in its progress, there is without doubt in many cases, I do not say in all, a so-called mixed infection present, which is to be differentiated from rheumatic fever proper. Maclagan's miasmatic theory has yielded for the time to more precise bacteriological views concerning the nature of rheumatism, and his name will be sought in vain, even in the valuable paper of Drs. Poynton and Paine which appeared in two of the September numbers of the *Lancet* in 1900. Maclagan was, of course, no bacteriologist. When he was a man of comparative leisure bacteriology was little cultivated, and when that science became more generally studied he was much too busy in the active work of his profession to have time to devote to its acquisition. In Poynton and Paine's paper a good historical resume will be found of the work done in this department prior to its publication. These writers believe that in the so-called *diplococcus rheumaticus* they have discovered, with their predecessors Wasserman, Westphal, and Triboulet, at least one cause of rheumatic fever. I am inclined myself to think that they have discovered a cause of one form of fever with rheumatic manifestations, as we understand them. There are other similar manifestations differing in details, some having purulent sequelæ from definite staphylococcal and streptococcal infection. Poynton himself believes that there is a malignant phase of simple infection. I think it might be fruitfully discussed whether there is not, in all malignant cases, an infection superadded to the agent, whatever it be, which induces that form of acute rheumatism which rapidly yields to the early and free use of the salicylates in many cases. We know that in some persistent cases of rheumatic fever, and of other phenomena attributed to the rheumatic poison, such as chorea, the salicylates frequently are of little service. Dr. W. B. Lees has argued that in some such cases persistency is due to insufficient dosage. This point also, I think, might be fruitfully discussed.

I am not aware that it has ever been experimentally determined whether the injection of the salicylates into the blood of animals in which the rheumatic phenomena have been induced by micrococcal infection has been followed by any modification of the process. From the opinion expressed by Poynton in a recent paper read before the Medical Society, I imagine that it has been found to be of no effect or that it is believed that it would be of no effect. If the point has not been actually determined, it would, I think, be well to make the observation. If the drug has no effect under these circumstances, the conclusion I should feel inclined to draw would be that the condition is not quite the same as that which we meet with in man in those cases in which the remedy is of decided and undoubted efficacy, judging from the cessation of pain and fever. The comparative readiness with which endocardial inflammation and vegetation, as also the infarction of the systemic circulation in other organs are produced experimentally, is to my mind rather indicative of the properties of some more powerfully septic agency than that which produces so-called simple acute rheumatism.

We are still on the threshold of serum therapy in respect to the treatment of malignant forms of the disease, but, little as has hitherto been the

benefit arising from this line of treatment, the recovery of patients who have ultimately died from some cause and revealed old valvular vegetations leads to the belief that a mode of self-immunisation has been secured by some such patients, and, therefore, that from serum therapy we have still much to hope for in malignant cases.

The theory of "change of type" in a disease to account for additional phenomena is delicate ground to tread. Change of type may mean alteration of agency in disease; in other words, other diseases. Notwithstanding, therefore, the valuable work done in this sphere by bacteriologists, I fear we must still say that, while rheumatic phenomena have been induced experimentally by germs cultivated from some cases of acute rheumatism, the identity of these cases with the majority of those which we recognise clinically as rheumatic fever has not yet been proved. In other words, that the essential infective agent which produces the non-malignant variety of that disease is still unknown.

I have purposely avoided, so far, any reference to rheumatoid conditions dependent upon an organism other than that of rheumatism, whatever that may be, such as the gonococcus or the streptococcus introduced into the system after surgical, obstetrical or other accidental sepsis, or after specific fevers. They are important conditions differentiable from acute rheumatism, if by no other characteristic than by the uselessness of the salicylates in their treatment. I am aware that in speaking so emphatically of the benefit of the salicylates I lay myself open to criticism, but as one who remembers the course of rheumatism before the era of salicylates and since I have no hesitation in expressing myself thus.

There are so many points inviting discussion in rheumatism, that even to touch upon all would occupy too much time. No doubt the debate will bring out some of those which I must omit. I shall, therefore, now only further suggest for discussion some of the possible avenues by which the infective agent in rheumatism may find an entrance into the system, and also some of the differences between the manifestation of the disease in the child and in the adult.

The throat has been suggested as the point of entrance of the germ of rheumatism by several authors, both at home and abroad, and the experience of many of us must afford corroboration of this view. A female child was brought to me some time ago at the Children's Hospital in Paddington Green suffering from tonsillitis. There was no complaint of any other distress. I was about to prescribe for her and send her home, when, as a matter of routine, I examined her chest and at once detected well-marked and unmistakable pericardial friction. The child was admitted under my care and the inflammation ran a favourable course. Although on a few occasions an apical systolic bruit was detected and was assumed to be endocarditic, the case recovered without permanent valvular disease. This, unfortunately, is not always or even often the case. In passing I may suggest that this disappearance of the evidence of rheumatic valvulitis might also be profitably discussed.

We know that there are natural protective agencies in the throat. A valuable paper on this subject was read by Dr. St. Clair Thomson before the Royal Medical and Chirurgical Society some

years ago. Surgeons have now, I believe, largely abandoned irrigating the naso-pharynx after the removal of adenoids, as they used to do at one time, on account of this normal defence against sepsis in this region. The same is true of the genital passage in the parturient woman. It would, indeed, have been strange if Nature had neglected to place a guard of some kind at important passes into the territories of life, where invasion from inimical extraneous agencies was most likely to occur. This is one of the chief functions of the skin itself, which we know swarms with germs, the removal of which occupies the modern surgeon as long as the performance of many operations, while the various glandular secretions guard the inner surfaces in like manner.

Now we know that one of the most common effects of exposure to cold, in weather which is at once both chilly and damp, is to produce catarrhal condition of the fauces and upper nasopharynx. It seems, therefore, quite probable that such a disorganisation of the natural faucial guards against germ invasion may well be a preliminary to rheumatism in some cases, because we know that the disease is most prevalent under such climatic conditions as favour the catarrhal states referred to. Theoretically, no doubt, the rheumatic germ may gain access by any disorganised or even abraded surface, as has been suggested by some; but it seems probable (and experience lends support to the view) that in subjects predisposed by some form of exhaustion, mental or physical, by worry or by work, or by imprudent or insufficient feeding, the catarrhal disorders of the throat and upper air passages are probably the conditions on which the rheumatic germ alights, and at times succeeds in developing to the detriment of its host.

Rheumatic fever in childbed is by no means unknown, but the possibilities of a septic invasion from other causes than rheumatic infection has to be borne in mind in these cases. Theoretically, of course, any surface internal or external may be an avenue for germ invasion under abnormal circumstances, but the coincidence of faucial inflammation and rheumatic fever is that which has attracted most notice clinically. Post-scarlatinal rheumatism, like that of parturition, is probably quite other than the disease we are now discussing.

The last point to which I shall refer is the frequently observed difference in the clinical manifestations of rheumatism in the child as compared with the adult.

There is no more common experience than to find when a child presents itself at hospital with organic heart disease that no information can be obtained as to a previous attack of rheumatism. On cross-examination some indefinite history of "rheumatics" or of growing pains may be elicited in some of these cases, and sometimes not even that. This ignorance of a probable previous source of the disease may, in the case of the struggling poor, be due to want of observation, but it also declares an important clinical fact, which was pointed out long ago by Dr. Cheadle and others, that in many cases of acute rheumatism in children the affection of the joints is not a prominent sign. Its absence or failure to note and remember it is therefore no argument against rheumatic fever having occurred. This absence of articular inflammation is much less

common in the adult, who is more likely to indicate his specific discomforts than is the child. If articular synovitis be less common in the child than in the adult nodule formation is more common, and may be detected in any situation in which there are tendinous structures such as in the neighbourhood of joints and also in other situations such as the head, where muscles are inserted. Dr. Poynton was fortunate enough to find the so-called *diplococcus rheumaticus* in such a nodule. That it is rheumatic in origin is now generally admitted.

The implication of the heart in the rheumatic process on the other hand is very common in children, and the tendency for carditis to become general—to involve all the structures and coverings of the heart, with the evil consequences of adherent pericardium, is more pronounced in children than in adults. Indeed, it is this greater penetrating quality of inflammation of the heart in children as compared with adults which has led Dr. Sturges and others to prefer the more general term carditis in such cases to those which indicate an affection of particular surfaces and structures in the organ.

The last point of difference between the rheumatic child and adult to which I shall refer is the greater liability of the former to evince the phenomena of chorea. This subject would be sufficient for a debate in itself. It may precede or it may follow rheumatism. It may also at times arise from some mental disturbance without rheumatic signs. Its frequent association with endocarditis which may leave permanent valvular disease, renders the care of the choreic child a great responsibility, and the more so when we remember that in the opinion of some, and my own experience agrees with this, the children showing most profound degrees of chorea with loss of motor power, and it may be of speech, are those who are least frequently affected at the same time with endocarditis. The serious case is sufficiently helpless to compel attention; it is the endocarditis of the trivial cases which is apt to be overlooked, and there is no greater sadness than to witness the permanent disablement of a young life at its very fountain.

I have now, Gentlemen, as was my duty in introducing a discussion, suggested many points for debate without dealing fully with any. I again thank you for having done me the honour to ask me to introduce this subject, and trust that this debate is but the precursor of many which may be conducted by this Association on medical topics of scientific interest and practical utility.

SOME ASPECTS OF RHEUMATISM IN CONNECTION WITH SKIN AFFECTIONS.

By DAVID WALSH, M.D. EDIN.

Senior Physician, Western Skin Hospital, London, W.

THAT the rheumatic diathesis is concerned in modifying if not in actually producing certain lesions of the skin has long been recognised by dermatologists. According to my own view, advanced first in 1890, rheumatism is an auto-genetic poison that acts on the skin by virtue of its excretory function. Acute rheumatism is now

(a) Read at the meeting of the Association of Medical Diplomates of Scotland, April 13th, 1905.

generally accepted as due to a specific micro-organism, and direct irritation of the skin by a toxic product therefrom may be inferred from the acrid, sour-smelling sweat of acute rheumatism. This peculiar sweating may be compared with that of phthisis, which, according to my "Excretory Irritation," of 1890, was probably due to the direct elimination by the skin of a toxic tuberculous product. An irritant of that kind has since been discovered in tuberculous sweat. The irritant may be a drug, a micro-organism, or the product of an autogenetic poison. In tubercle we know that the bacillus may attack the skin like any of the other excretory organs of the body. In rheumatism irritation of the skin may result from toxins, as in sweat, and presumably in urticaria, and so on, and if rheumatism be due to a specific organism, it is reasonable to assume that some of the skin lesions associated with that malady may be due to the micro-organisms themselves. At any rate, I am at present searching for Poynton's diplococcus in the skin, and should be glad if others would look for it in any cutaneous rash occurring in rheumatic subjects.

In the more chronic forms of rheumatism the affection is more or less definitely connected with various skin eruptions.

One of the most remarkable, peliosis or purpura rheumatica, is, as we all know, characterised by an eruption of red patches that do not fade on pressure, together with pains in some of the joints, most commonly the knees and ankles. Sometimes the purpura becomes hæmorrhagic. It is often met with in patients affected with valvular heart disease, but most likely because all three affections, namely, of skin, joints, and heart, are due to a common cause, rheumatism.

Probably some cases resembling purpura rheumatica are due to other toxic conditions which require careful differentiation.

There is a curious and rare condition of dermatalgia, or pain in the skin described by some writers as rheumatism of the skin. It is characterised by local pain in the skin without structural changes, and in the great majority of cases it is associated with a definite history of rheumatism and is excited by exposure to cold. The pain is spontaneous as well as readily excitable, and is thus distinguishable from hyperæsthesia. Cold here appears to have a direct determining effect in localising the action of a rheumatic poison of some kind.

One of the most interesting forms of rheumatic skin trouble associated with joint pains is that of erythema nodosum. It is sometimes seen on the legs during an attack of rheumatic fever. The most common form is that met with in young persons, especially in girls or women under thirty years of age. Oval or rounded, tender, rosy, slightly elevated tumours, apparently in crops that last about a week, usually on the legs, but sometimes on the arms. I have detailed these points because I wish to draw attention to the fact that occasionally the spots are hæmorrhagic, thus showing a close analogy with purpura rheumatica. There must be some fairly definite modifying conditions with which we are unacquainted as regards a condition thus peculiar and characteristic. The swellings of erythema nodosum affecting certain anatomical sites, and further modified by sex and age, mark an interesting

clinical picture hardly less definite than inexplicable.

Speaking generally of the relation of the rheumatic diathesis to skin affections, in common with many dermatologists, I believe it to modify greatly the course of not a few skin affections. Of this a good example may be found in seborrhœa, both of the scalp and of the body. For several years past I have made careful investigation into the family and personal history of all cases of seborrhœa, both of scalp and of body, that have come under observation both in hospital and in private practice. The result has been, broadly, that in severe cases a distinct history of gout, rheumatism, or of rheumatic fever has been almost invariably forthcoming. For instance, a girl of ten years was brought to me at hospital recently with a severe dry seborrhœa of the scalp and body, the limbs being spattered profusely with yellow scaly patches varying in size from a pin-head to a threepenny-bit. A glance at the case suggested a rheumatic history, but the mother said there was none in the family, and that the girl had always enjoyed good health. On her next visit to the hospital, cross-examination showed that the girl had suffered from rheumatic fever. Under salicylate of soda the scurf improved rapidly, and the rash rapidly melted away.

This leads to another point of some interest and importance. In former days the scaly rash in the foregoing case would have been called psoriasis. Nowadays some dermatologists include all psoriasis under the heading of seborrhœa. It is a well-known fact that psoriasis is sometimes cured by large doses of salicylate of soda. More often it is not in the least benefited by that drug. May it not be that the cases which are cured by a remedy that clearly exercises a specific influence upon rheumatism may have a rheumatic origin? In the case I have related the rash cured by the salicylate was from my point of view a seborrhœic invasion of scalp and skin, exaggerated, fostered, and, as it were, kept alive by the rheumatic diathesis. The salicylate purified the soil, and the local remedies cured the seborrhœa. If this view be correct, it gives a sufficient answer to the school of dermatologists who claim that skin diseases should be treated simply and solely by local means.

Rheumatic nodules are not often met with in skin practice. I have met with some interesting cases, notably one in which two nodules, a little below the olecranon, were absolutely symmetrical. The patient was an elderly man suffering from rheumatoid arthritis of rheumatic origin, and the case was shown at the Dermatological Society of Great Britain and Ireland.

As physician to the Tallerman Free Institute at one time I had a large experience of the hot air treatment of joint affections. There is no need to enter into the merits of a method that has admittedly revolutionised the treatment of rheumatic, gouty and allied affections. I may say generally that where a clear rheumatic history could be obtained the prognosis in arthritic troubles was always more hopeful, no matter how severe the individual case might look. In other words, the chronic rheumatic joint is only one of various conditions classed under rheumatoid affections, but is often a recoverable condition even in advanced stages. The brilliant success of hot

air in these conditions led me to try it in various chronic eczematous and scaly diseases of the skin. In many obdurate and old-standing eczemas results were often immediate, and in some instances lasting. One case of severe generalised eczema in a patient suffering from mild rheumatoid polyarthritis was cured by treating one arm alone in the hot cylinder. The disease recurred in two years' time, and was again relieved.

A severe and chronic psoriasis, of several years standing, in a young unmarried woman, was completely cured by a prolonged series of hot air local baths. It had previously resisted all forms of medical treatment.

It seems to me that the cutaneous aspect occupies a place in the study of rheumatism that has hardly been hitherto adequately recognised. Most physicians and most dermatologists recognise a general connection between the two conditions, but the matter has not yet been worked out. One practical point in my experience is that anti-rheumatic remedies, notably salicylate of soda and the hot air bath, will in not a few cases effect a cure in certain obstinate diseases of the skin unattainable in any other way.

SOME PRACTICAL ISSUES WHICH ARISE OUT OF THE UNCERTAIN SIGNIFICANCE OF THE TERM "RHEUMATISM" (a)

By C. O. HAWTHORNE, M.D. Glasg., M.R.C.P.
Lond., F.F.P.S. Glasg.

Examiner in Medicine and Clinical Medicine in the University of Aberdeen, Physician to the Central London Ophthalmic Hospital, Assistant Physician to the North-West London Hospital and to the Royal Waterloo Hospital for Children and Women.

In the very able and suggestive paper with which Dr. Morison has opened this discussion he has paid a just and eloquent tribute to the work and memory of the late Dr. Maclagan, and to all that he has said on this point this Association may well be content to attach its endorsement. Dr. Morison has raised a number of questions, some of academic, others of severely practical interest, and it is to be expected that some of these will give rise to much difference of opinion. Personally, I am disposed to hint a measure of dissent from the proposition in which he appears to imply that the treatment of rheumatism by alkalies is an antiquated proceeding for which, in the presence of the salicin group, there is neither justification nor excuse. On the contrary, while admitting the supreme value of the latter in cases of acute rheumatism or rheumatic fever, the alkalies, in my experience, are particularly useful in cases of a less acute order—cases in which the pyrexia is only moderate and the joint pains are not extreme. Only it is necessary to remember that in order to give the treatment by alkalies fair play the doses of the salts selected should be sufficient to produce an alkaline reaction in the urine. The quantity necessary to secure this result varies widely in different individuals, and hence no absolute dose can be stated. The practical point is that it is the alkalinity of the urine which alone affords ground for the conclusion that the patient is receiving a sufficiently large dose.

Turning now to the general question, it must be allowed that any discussion on the subject of rheumatism is handicapped by the absence of a precise definition of the term. Recent bacteriological work seems to render it probable that the supreme manifestation of rheumatism which we call rheumatic fever is dependent on the activity of micro-organisms. If this prove to be correct, there will exist an etiological criterion by which, in any given instance, the validity or otherwise of the application of the term "rheumatic" may be determined. But it is obvious that we are at present a long way from the possibility of applying any such test to the numerous clinical occurrences which are more or less generally grouped under the title of rheumatism. Whether these do or do not depend upon the same cause as that which produces rheumatic fever we have no exact knowledge, and hence, however strongly we may suspect the relationship on grounds of clinical experience, we are not in a position to frame a secure and inclusive scientific definition. Thus we must needs fall back on convention or "use and wont," and in doing so there is the possibility that in the course of the discussion we shall not all use the term in one and the same sense. What I wish to draw attention to more particularly is some of the practical consequences of this insecurity of definition. And the first illustration I find in the manifestation in children of such events as growing pains, tonsillitis, chorea, &c. Professional opinion strongly inclines to the view that these are generally, if not invariably, evidences of rheumatism, and most certainly each of them is apt to be associated with that most disastrous result of rheumatism, namely, valvular or other disease of the heart. But whilst this is the attitude of the medical profession, it is not the attitude of the public. For the public, the definition of rheumatism remains restricted to pains in the joints and muscles. And, as a practical result, parents never suspect that a number of comparatively minor ailments affecting their children carry even a greater risk of heart disease than is involved in an attack of rheumatic fever. The consequence is that many of these children during their relatively trifling illnesses are treated in a somewhat cursory fashion, and in particular do not receive the complete and prolonged rest which we recognise to be the best security against the supervention of endocarditis and valvular damage. Every practitioner sees numerous cases in which he finds physical evidences of such damage, and in which the possibility of rheumatism is denied. The explanation is that the public and professional applications of this term differ. And, further, I suggest that the more frequent development of heart disease in the non-arthritic rheumatism of early life and its less frequent occurrence in the acute polyarthritis of adults are due, at least in part, to the absence of prompt and complete rest in the former, and to the practice of this discipline in the latter. The adult with swollen and painful joints must rest perforce. The child with "growing pains" or a "sore throat" is under no such compulsion. Now, out of all this comes the question, whether any practical steps can be taken to protect children who inherit a rheumatic strain from the development of heart disease as a consequence of those slight illnesses which the profession does, but the public does not, recognise as rheumatism. The answer

(a) A Contribution to a Discussion on "Rheumatism" at a Meeting of the Scottish Medical Diplomates Association.

is obvious, that the public must be educated on this point; and the education must be conducted by the family medical adviser. In other words, let it be recognised as a duty incumbent on every practitioner to warn the parents of families in whom there is a known tendency to rheumatism of the risks which their children inherit and of the necessity for immediate and complete rest, even in complaints that seem to be of a minor order. It is surely not right to wait until the mischief is done. Rather, as we all recognise, the highest duty of the profession is the prevention of disease and suffering. And I venture to think it reasonable to believe that were the policy here advocated universally adopted on the first hint in any family of the presence of a rheumatic strain something would be done to diminish the prevalence of heart disease in childhood and early life. The profession would, at all events, have cleared its conscience by placing at the disposal of those members of the public more immediately concerned the best known method of saving their children from a serious and irremediable disaster.

A second illustration of the evil consequences which attend an uncertain definition of the term "rheumatism" is afforded by those, for the most part, chronic disorders and deformities of joints which are placed under such names as chronic rheumatism, rheumatoid arthritis, rheumatic gout, and so on. Frequent and acute discussions have been conducted as to whether these conditions are or are not "rheumatic," and when we know the cause of rheumatism, but hardly before, such discussions may be ripe for settlement. In the meantime, as I have ventured to suggest elsewhere, the safe plan is to avoid the use of terms which involve adhesion to unproved theories, and merely to name such diseased states of the joints "chronic arthritis." Curiously enough, whilst the profession is uncertain whether such chronic disorders of the joints are or are not rheumatic, the public suffers from no such hesitation. In the popular judgment "chronic rheumatism" is the correct style and title, though in individual instances a personal preference suggests "gout" or even "rheumatic gout," and it cannot be said that such an arrangement of terms is destitute of professional sanction. The consequence is that many such patients, either on their own responsibility or acting under advice, are placed on a more or less restricted diet and receive over long periods such remedies as sodium salicylate or the organic potassium compounds. No one who has much experience of these cases will, I fancy, say that one and the same programme is suitable for them all, but it is beyond question that patients who suffer from these chronic disorders of the joints need not a restricted, but rather a liberal regimen, and that tonic, and not depressant remedies are the more suitable. In the early stages such disorders appear simply as pains in the joints, particularly, perhaps, in the hands and feet. They are then considered to be rheumatism, and are often treated as above indicated with, I believe, unfortunate results. On the other hand, a persistent tonic discipline, in the early stage of these cases, has an extremely good influence, and often succeeds in preventing the development of those deformed and disabling conditions of the joints which, when once produced, are hardly susceptible of relief.

Thus the two illustrations I have here submitted

of the indefinite and varying application of the term "rheumatism" have important practical relationships, and suggest that there may be more in a name than a certain hackneyed quotation would seem to allow.

A CASE OF CARBON MONOXIDE POISONING.

By WM. J. THOMPSON, M.D. DUB., F.R.C.P.

Physician to Jervis Street Hospital, Dublin, and
Consulting Physician to the National Hospital for Consumption, Dublin.

DURING the past few years quite a number of cases of carbon-monoxide poisoning have occurred in Dublin, owing to the mixture of water gas with the coal gas as supplied by our gas company, resulting, unfortunately, in the loss of life. Last Session this section of the Royal Academy of Medicine had the privilege of having a most valuable and scientific paper from Professor McWeeney on this subject, in which he minutely describes the changes he had observed in the blood as well as other changes in different organs as found by him at *post-mortem* examinations.

I have had under my care in Jervis Street Hospital three cases within the past few years, and as even the larger text books are rather indefinite in their description of symptoms and treatment I thought perhaps the description of a case admitted under my care last year might be of some interest to the members of this Section. The case, I may say, is almost unique in how the "gas poisoning was contracted, and in looking up the literature of the subject I can find no similar case recorded.

At 7.30 a.m. on November 12th last, F. H., a strong, able-bodied, seafaring man, *æt.* 37, was admitted to hospital, and I saw him a quarter of an hour later. The following is the history of the case we got from his companions. He was by occupation cook in one of the dredgers used at the mouth of the Liffey, and belonging to the Port and Docks Board. On the previous evening, as was his usual custom, he retired to the skipper's room, and not making his appearance at six o'clock next morning, one of the crew knocked at the door, and getting no answer it was burst open. The patient was found lying on the floor on his left side, apparently lifeless. That night the dredger was anchored some distance down the river, and although all possible haste was made it was 1½ hours afterwards before he was brought to the hospital by the City ambulance. It seems that on these dredgers there are eleven of a crew:—The skipper, cook, and nine others, and at night only two of the crew, who act as watchmen, remain on board as well as the cook. It was always the custom for the cook to retire to this room for the night. The room is described as being about 17 ft. long by 8 ft. wide by 7 ft. height—cubical content, 952 ft., and when the door is closed there is no ventilation. At one end of the room there is a small stove in which during the winter there is a fire. When retiring that night (we found out from the patient afterwards) he closed and bolted the door, and as the fire was low he put on one large block of Scotch steam coal. He remembered

(a) Paper read at the State Medicine Section, Royal Academy of Medicine, in Ireland, April 14th, 1905.

nothing more until he found himself in hospital.

When I saw the patient the colour, not only of his face, but also of the whole body, was dusky, dark and greyish; he had well-marked, short, shallow, heavy, and stertorous breathing (24 per minute); there was a slight tremor of all the muscles of the body, especially of the masseters, and this tremor was rhythmical with an interval of about two minutes. The pupils were slightly irregular, that of the right eye being slightly dilated, and that of the left eye slightly contracted—both were insensible to very strong light. The abdomen was retracted. The surface of the body was icy cold, although the temperature taken in the rectum was 99.6. The mouth was tightly closed; the mucous membrane of the nose, as well as the inside of the ear, was anæsthetic, and a catheter was passed without the patient apparently feeling it. The whole surface of the body was in the same state of anæsthesia. There was also analgesia, and the sensibility to heat and cold was lost. The pulse was thready, small, easily compressible, and could not be counted; the heart sounds were almost inaudible, that of the first sound was practically lost. The superficial reflexes, including the conjunctival, were lost; there was well marked rigidity of all the muscles of the body, more particularly of the arms. There was no urine in the bladder, although it was at least twelve hours since he had micturated. The blood when drawn off had the bright red, cherry-like, characteristic colour of carbon-monoxide poisoning, and Professor McWeeney concurs in this view.

The other two cases which came under my care were affected by inhaling the ordinary gas, as supplied by our gas company, which, as is well known, is charged with carburetted water gas sometimes to the extent of 16 per cent., whereas in ordinary coal gas the percentage is rarely more than 6 per cent. This case illustrated how carbon-monoxide poisoning may accidentally take place. Dr. Glaister, Professor of Forensic Medicine and Public Health in the University of Glasgow, in his well-known text book describes the celebrated Snaefel case as occurring from burning timber in which combustion was not active because of imperfect supply of air. The probable explanation of this case is that there was slow combustion of the large lump of coal owing to the deficient supply of air, due to the smallness of the room and the want of ventilation. As a matter of fact, there was still a smouldering fire in the stove when the door was burst open. It is scarcely necessary to mention that carbon-monoxide poisoning is a typical example of a cumulative poison. As is well known, its powerful toxic action is due to its affinity for hæmoglobin. Some authorities state that that affinity is from 150 to 200 times greater than the affinity of oxygen for hæmoglobin. When CO. is inhaled it gradually displaces the O of the hæmoglobin, and forms carboxy-hæmoglobin, a much more stable compound than oxhæmoglobin. In the living body carboxy-hæmoglobin neither takes up nor gives off O., and is therefore incapable of acting as an O. carrier to the tissues. According to Haldane, it is necessary in human beings that the blood is one-third saturated before the characteristic symptoms become urgent, and this explains the delay in the appearance of symptoms. The combination is sufficiently intimate

to resist the action of reducing agents, but it gradually yields to the action of O. This fact is worthy of note, as it gives us a hint in treatment, for the administration of O. is of the utmost importance. To be of any service, it must be used continually and for a length of time. It is proved experimentally that if air or O. is passed for a long time through a solution of carboxy-hæmoglobin the CO. is slowly and gradually separated from the hæmoglobin and O. takes its place. This point was well illustrated in my first case, which Professor McWeeney mentioned in his paper of last year. The patient was three days in hospital before death, and during that time had inhaled large quantities of O. It was found at the *post-mortem* that there was no carboxy-hæmoglobin, showing that the use of the O. inhaled had doubtless effected the complete removal of the CO.

Dr. Dixon Mann, Professor of Forensic Medicine and Toxicology in Owens College, Manchester, in his valuable text book, says that it has been stated that CO. possesses an intrinsic action in addition to its power of depriving the tissue of O. Linossier of Lyons, from experiments, concludes that CO. does possess such an action, while on the other hand, such a well-known authority as Haldane states that CO. acts solely by combining with hæmoglobin, and in no other way.

The treatment adopted in this case was the continuous use of O., the prolonged carrying on of artificial respiration, hypodermic injections of ether, strychnine and digitalin. Injection per rectum of stimulants and nutrient enemata. In addition, heat was applied all round the body, and what I consider most useful, electricity along the course of the phrenic nerves and the spine. I have also used saline injections, but, in my opinion, without any beneficial result. Bleeding also seems to be of use.

As I have stated before, the patient's bladder was empty on admission. During the first day in hospital he passed 9 oz., on the second day 15, and on the third day 23 oz. The quantity passed next day, that is, the fourth, was normal. No trace of albumin or sugar could be detected, although some authors state that frequently sugar is present. The amount of urea passed was about normal per ounce. This is a contrast to my first patient, who during the three days before death secreted no urine, and at the *post-mortem* there was found extreme congestion of the interlobular vessels of the kidneys.

The patient did not regain consciousness until late in the afternoon, and from that time made a rapid recovery. He left hospital on November 27th, fifteen days after admission, apparently nothing the worse for his illness. In many of the cases recorded, convalescence has been very slow, and frequently some organic disease was contracted.

Clinical Records.

A CASE OF SEVERE TUBERCULOUS OSTEO-MYELITIS.

Under the care of DR. FORBES H. WOLFE,
Tighnabruaich, Kyle of Bute.

H. B., a girl, æt. 6½, was first seen by me in May, 1900. Her father is a gamekeeper who lives in a remote country district. The other children of the family are quite healthy. The mother is a strong

healthy woman. The history of the case as given to me by the parents was that "one morning, five weeks ago, the child went to school quite well and came home at night crying with the pain of her foot." No history of any injury could be elicited. "The local practitioner was called to see her and ordered poultices, which were applied constantly for five weeks, but without any beneficial result, the doctor calling frequently to see the limb, but never doing anything for it."

There is no doubt that in many such cases the "vis medicatrix naturæ" works some cures, but in the majority an early free incision gives a more rapid and gratifying result.

When I first saw the case the condition of matters was: The right leg, from above the patella down to the ankle-joint was covered with a tough, caseating mass, from the substance of which numerous sinuses could be seen discharging foul pus. Intense pain, which was much exaggerated when any movement was attempted, was complained of especially over the knee-joint. Sensation over the part of the limb affected was diminished and the condition appeared to be rapidly approaching a state of gangrene. The child was a girl of beautiful delicate features and fine glossy jet black hair, with long pencilled eyelashes, so often associated with the "tuberculous diathesis." With the help of the district nurse I gave an anæsthetic and scraped off all the caseating mass, and for some days afterwards the nurse applied hot fomentations of lint saturated with boracic acid. I then made a free incision extending along the whole length of the tibia and removed the whole of the middle third of that bone, leaving a thin layer on the posterior surface, and scraped away all the diseased tissue formed above and below these points. The upper and lower portions of the tibia were fortunately found to be healthy. The cavity was then packed with iodoform gauze and dressed every three days. No drug treatment was prescribed. Well-boiled porridge with cream was given every morning, and abundance of fresh milk during the day at first, the patient being gradually put on the ordinary diet of the family, which consists mainly of porridge, milk, fish, potatoes, bread, eggs, and occasionally butcher's meat.

The patient made an uneventful recovery, and the whole surface was entirely healed by the end of August, 1900, since when there has been no recurrence.

The patient is now a tall, handsome girl of 11½ years, and when I say that she can walk to school in the morning and home again in the evening—a distance of three miles each way—without any inconvenience or limp, the success of the operation cannot be doubted.

This case, I think, illustrates some interesting points—viz.:—(1) The sudden onset of periostitis without any apparent exciting cause; (2) the danger of the "expectant" treatment in such a case; (3) when domestic poultices are applied to an open wound communicating with bone they usually act as allies to pus micro-organisms in their work of tissue destroying; (4) the benefit derived from pure country air and abundance of milk while the healing process is going on.

Transactions of Societies.

ROYAL ACADEMY OF MEDICINE IN IRELAND.
SECTION OF STATE MEDICINE.
MEETING HELD FRIDAY, APRIL 14TH, 1905.

SIR JOHN W. MOORE, M.D., President, in the chair.

ASYLUM-DYSENTERY.

PROFESSOR E. J. MCWEENEY showed a large series of cultures of an organism which he had isolated by the Drigalski place-method from the muco-purulent stools of a typical case of this disease. He also showed, for purposes of comparison, parallel cultures of genuine typhoid, and of two strains of *B. Coli*, one derived from human stools and highly pathogenic for rabbits, the other freshly cultivated from a pure water-supply and presumably non-pathogenic. The dysentery or-

ganism was thus shown to have the closest cultural resemblance to the typhoid, the chief morphological difference being its non-motility. The chief cultural differences appeared on Endo's fuchsin-medium and in mannite agar. Exhibitor discussed the question as to the identity of the organism isolated by him with that of Shiga and Kruse. He expressed his thanks to Dr. Heffernan, Assistant Medical Officer of the Clonmel District Asylum, to whom he was indebted for the material.

The PRESIDENT thanked Professor McWeeney for his very interesting exhibit, which treated of a subject of the greatest importance to workers in preventive medicine. He hoped that during the coming summer Dr. McWeeney would devote some study to the bacteriology of the diarrhoea of children, as he thought it probable that some, at least, of these cases were due to the presence of the bacillus of dysentery.

Dr. A. R. PARSONS expressed the hope that Dr. McWeeney would be able to keep a strain of this micro-organism growing, so that other cases of asylum dysentery might be tested against it. He thought that it was very probable that in the future the treatment of dysentery would largely depend on the bacteriological diagnosis.

Dr. W. J. THOMPSON described a case of "Poisoning by Carbon Monoxide," which will be found on page 426.

Professor MCWEENEY stated that he had made an examination of the blood from Dr. Thompson's patient. The first specimen he examined was too small in amount for detailed examination, but presented all the appearances of the presence of CO gas combined with hæmoglobin. At a subsequent examination no trace of CO gas was found, and the leucocyte count was also normal. Dr. McWeeney thought that Dr. Thompson deserved the greatest credit for his active and successful treatment of the case.

Dr. THOMPSON replied.

Dr. W. I. de C. WHEELER gave a short account of a case of strychnine poisoning which had come under his notice.

ASSOCIATION OF MEDICAL DIPLOMATES OF SCOTLAND.

MEETING HELD IN THE MEDICAL SOCIETY'S ROOMS,
LONDON, APRIL 13TH, 1905.

The President, CLAUDE ST. AUBYN-FARRER, Esq., in the Chair.

AFTER the general business of the Society, a discussion was opened on

RHEUMATISM

by Dr. A. MORISON. (This paper will be found fully reported on page 421).

Dr. C. O. HAWTHORNE said he should like to emphasise the value of alkalies in the treatment of some forms of rheumatism. He followed with an address which will be found on page 425.

Dr. LEONARD GUTHRIE said that special attention was first drawn to the rheumatism of childhood—especially as to rheumatic nodules—about twenty years ago by Cheadle, Warner and others. The rheumatic nodules were practically confined to children. The nodules, in their first stage, consisted of a thrombosis, which afterwards became fibrous, and in one case under his notice lasted for two years. The diplococcus of Poynton and Payne had been found in these nodules—cultivated in outside media and the cultures injected into rabbits had produced polyarthritis and heart disease. He had always thought chorea could not be a general toxic disturbance, but rather a local lesion due to micro-organisms. The condition of thrombosis was indicated by the fact that the chorea was always recoverable. He had found that salicylates always relieved the pain and reduced temperature in children suffering from rheumatic attacks. Personally he gave salicylate of quinine rather than of soda, and aspirin.

Dr. FITZGERALD POWELL believed the virus of rheumatism was introduced into the system chiefly by way of the naso-pharynx, by the tonsils, pharynx or

nasal cavity. If that possibility were borne in mind, especially in children, he considered the rheumatism might often be checked or controlled in its earlier stages. Malignancy or otherwise in acute rheumatism might be accounted by the state of malignancy of the microbe, or by the influence of mixed infection. In all cases the throat and nose should be treated, and salicylates given; the alkalies would, no doubt, be useful in neutralising acid secretions. Anyway, he had found alkalies often useful.

Dr. C. PARKER observed he had found acute rheumatism more common in hot, dry weather, when there had been no rain for some weeks. That experience was contrary to the generally-accepted theory of damp, warm weather as a predisposing cause. He thought that not only acute rheumatism, but many acute infections started from the throat, as scarlet fever, influenza and German measles.

Dr. LEIGH (Southend) said that although March had been remarkably fine, the first two weeks of April had provided almost an epidemic of follicular tonsillitis. In one case, at least, rheumatism followed, with purpura on the fingers.

Dr. DAVID WALSH discussed the subject of rheumatism in skin diseases (this will be found on page 423.)

Mr. SYDNEY STEPHENSON followed on some points of rheumatism in connection with the eye which we hope to publish in full in an early number.

Dr. LEWIS (St. Leonards) said that in general practice he had often noticed that in many cases of tonsillitis local treatment of the fauces was of great value. He felt convinced of the fact of oro-nasal infection; he had seen it in influenza, and had found that a nasal antiseptic spray limited the spread of infection. Treatment was all important from the point of view of general practice. He would like to know the relative value of salicylate of quinine, of soda and of potash. Personally he thought the best results were obtained from salicylate of soda combined with alkalies. He would like to know the dose of salicylate of quinine.

Dr. GUTHRIE said the dose was 2½ grains for a child and 5 to 15 for an adult.

The PRESIDENT said that as a general practitioner in the early stage he gave salicylate of soda combined with carbonate of ammonia, while later he gave salicylate of quinine. A generous diet was essential. In his opinion, if an acute affection did not yield to salicylate of soda it might be concluded it was not rheumatism. The general practitioner was interested in treatment rather than in elaborate diagnosis. In his case cure was essential to his reputation and the success of his professional career.

Dr. MORISON, in reply, congratulated the Society on a most satisfactory discussion. The condition of the children of rheumatic parents was of great importance. Some philanthropic agency was needed to take charge of them when the urgent symptoms waned, and there was no room for them in the hospitals. They were sent out only too often to relapse and to get damaged hearts. He thought that in the brain some condition of the meninges comparable with erythema of the skin might be answerable for the chorea. The embolic theory was scarcely substantiated, because the choreic lesion was not permanent. As to Dr. Parker's observation that acute rheumatism was more prevalent in dry weather, if so it was probably due to conditions favourable to bacterial activity. Possibly the oro-nasal guards might be injured by climatic or meteorological conditions. He thought the diplococcus of rheumatism might be related to a streptococcus. He was not sure he had not forgotten how to use the salicylates. Maclagan gave his patients 30 grains of salicin every hour until the system was saturated. We now think 18 to 30 grains of the salicylate bold dosage. Salicin is not depressant, and Maclagan's astonishing results were obtained by pushing a cumulative non-depressant drug. He advised the modern bacteriologist to consult Maclagan's book, which had established a new era in the study of rheumatism, even if he had simply chanced on a happy accident as the result of an erroneous hypothesis.

LARYNGOLOGICAL SOCIETY OF LONDON.

MEETING HELD APRIL 7TH, 1905.

Mr. CHARTERS SYMONDS, President, in the Chair.

THE following cases and specimens were shown:—

Dr. H. J. DAVIS, a case of (?) "Traumatic Perforation of the Nasal Septum" in a boy, æt. 17, who was engaged in flour mills. Epistaxis had followed the injury. He also showed a piece of blue chalk, ¼-inch long, which had remained three weeks impacted in the respiratory passage of a boy, æt. 10. Dyspnoea and bronchitis had supervened. The chalk was dislodged and swallowed during laryngoscopic examination, and was passed per rectum.

Dr. JOHNSON HORNE showed a case of "Malignant Disease of the Larynx."

Dr. KELSON exhibited a case of "Lingual Growth" in a man, æt. 45. Some doubts were expressed as to whether this was a papilloma or a thyro-lingual cyst.

Dr. LACK showed a case of deformity of the hard palate and teeth due to nasal obstruction in a boy with facial paralysis, showing the factors in the causation of high-arched palate.

Dr. PEGLER showed a case of broadening of the external nose caused by tense symmetrical swellings attached to the cartilaginous septum. He also showed an obstinate crusting and pus formation in a man, æt. 40, shown for diagnosis. Both turbinals had been removed.

Mr. ROBINSON showed a case of "Angio Fibroma of the Vocal Cord," and

Mr. CHARTERS SYMONDS a very interesting case of "Angioma of the Larynx," in a man, æt. 34. He also showed a woman, æt. 52, in whom the larynx and thyroid gland had been extirpated for cancer. Also a case of papilloma of the larynx in a man, æt. 30.

Mr. WAGGETT showed a case of frontal sinus empyema cured by operation, and

Dr. TILLY showed two cases. The first was a woman, æt. 31, with subglottic hyperplasia, causing stenosis of the trachea and some difficulty in breathing. It was thought to be probably syphilitic in origin. The second case (one for diagnosis) was in a man, æt. 64, with recurrent paralysis of the right vocal cord, and some difficulty in swallowing. The right pupil was contracted and there was slight ptosis of the eyelid, and wasting of the upper part of the right trapezius. Members considered that the cause of the trouble was peripheral and not central.

Dr. DONELAN showed a man, æt. 39, with lateral ulceration of the larynx. There had been hoarseness for about two months, but there was no history of syphilis.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

CLINICAL MEETING HELD FRIDAY, APRIL 7TH, 1905.

Mr. C. M. TUKE, President, in the Chair.

Mr. J. HOWELL EVANS showed a "Cervical Auricle" which he removed from a child, and by the aid of lantern slides, explained the origin of these growths.

Dr. SEYMOUR TAYLOR showed a case of "Acromegaly," the subject being a woman, æt. 28, who had wonderfully improved under treatment of pituitary gland extract.

Dr. E. E. RUSSELL remarked on the tendency in some of these cases of acromegaly for the disease to undergo spontaneous arrest.

Dr. LEONARD DOBSON exhibited a case of "Congenital Ataxia" in a boy, æt. 8½. The boy was born prematurely and delivered with forceps. He had been treated during infancy for rickets. He could not talk or attempt to walk until he was four years old. He now walks with a well-marked ataxic gait, and has constant choreic movements whilst awake, but these movements cease during sleep. His general health is very good, and he is a bright intelligent boy, cleanly in his habits, and has complete control over his sphincters.

Dr. H. P. POTTER suggested large doses of arsenic

to allay the involuntary choreic movements, with which treatment Dr. ARTHUR SAUNDERS agreed, and who attributed the condition as probably due to meningeal hæmorrhage at time of birth. He found considerable benefit derived from administration of hyoscine in increasing doses three times a day.

Dr. G. E. SHUTTLEWORTH said that a degree of inhibitory and co-ordinative power may be gradually developed by judicious muscular exercises, and mentioned an example of a boy under his care at the Royal Albert Asylum, Ancaster, who gradually was taught to use carving tools and eventually became a teacher of wood-carving at the Asylum.

Dr. H. B. BALL showed a case of "Chronic Middle-ear Suppuration" with thrombosis of the lateral sinus, upon which in addition to the ordinary mastoid operation, Dr. Ball laid open the lateral sinus, removed a broken down clot and ligatured the internal jugular vein.

Dr. ARTHUR SAUNDERS brought a case of "Congenital Heart Disease" before the notice of the meeting, the patient being a girl, æt. 15. The chief point of interest in the case is the peculiar character of the murmur. This is best heard at the pulmonary base, and is of a roaring character lasting throughout both systole and diastole.

Dr. SEYMOUR TAYLOR remarked how impossible it was to diagnose the exact condition of these cases of congenital heart diseases.

Dr. SAUNDERS also showed a Mongolian idiot, æt. 2 years 4 months, upon which case Dr. G. E. SHUTTLEWORTH offered some interesting remarks.

Mr. J. R. LUNN exhibited a case of tumour of the tongue in a girl, æt. 12, which was of doubtful origin.

Mr. E. P. PATON considered the case to be an example of lymphangiectasis.

Mr. LUNN also showed a case of "Chronic Syphilitic Glossitis."

Dr. A. E. RUSSELL showed two cases of "Progressive muscular Atrophy," occurring in two cousins. The family history was very interesting, as, although the grandfather and grandfather's brothers were affected, the next generation escaped, and the disease appeared in the grandsons.

LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD APRIL 13TH, 1905.

DR. JAMES BARR, President, in the Chair.

Dr. WILLIAM WILLIAMS demonstrated an improved method of chest aspiration.

Dr. J. C. M. GIVEN related a case of "Paramyoclonus Multiplex," occurring in a man, æt. 21. The contractions were unilateral in distribution, affecting mainly the muscles of the forearm, leg and abdomen on the left side. The patient's mother had suffered from chorea gravidarum whilst pregnant with this child. He had had two severe accidents at long intervals, to which he attributed the commencement and increase of the disease. The administration of hyoscine hydrobromate gr. 1-100 twice daily, had been followed by distinct improvement.

Dr. A. C. WILSON related five cases of hæmorrhage apparently due to high arterial tension. Case 1 was that of a youth, æt. 20, who from early childhood had been subject to nose-bleedings. During the week he had two severe attacks of hæmatemesis. The radial pulse denoted high arterial tension, and there was no pain or tenderness over the epigastrium suggestive of gastric ulcer. The patient quickly improved on taking large doses of perchloride of iron. Case 2 was that of an elderly lady, the subject of arterio-sclerosis. She was suddenly seized with dizziness, and her congested face and slow high tension pulse threatened an attack of apoplexy. Fortunately this was averted by profuse bleeding from the nose. Case 3 was one of cerebral hæmorrhage which occurred in a man, æt. 38. There was aphasia and paralysis of the right side. He gradually made a complete recovery. Case 4

was that of a lady, æt. 45, who for the last seventeen years has had attacks of hæmoptysis, at one time thought to be due to phthisis. Her general health is excellent; the sputum does not contain tubercle bacilli. Case 5 was also a case of hæmoptysis. The patient, a man, æt. 48, has for six years been subject to slight bleeding attacks. There are no physical signs of phthisis and the sputum does not contain tubercle bacilli.

Dr. CHARLES PINKERTON related a case of "Floating Kidney" in which the symptoms closely resembled those due to gall-stones. The patient was a married woman, æt. 38, who during the last eighteen months had twelve attacks of great pain in the right side with sickness, followed by jaundice. She had lost a stone in weight during that time. Physical examination revealed a floating kidney and a dilated stomach. A belt for the kidney was ordered, but before it arrived she had another attack, a typical Dietl's crisis, attended, however, by jaundice. After wearing the belt she rapidly gained in health and weight, and has remained perfectly free from all attacks since.

Dr. T. R. BRADSHAW referred to a case the converse of this, in which a woman had a freely movable kidney and hepatic pains, but an operation for the removal of gall stones completely cured her.

Dr. R. J. H. BUCHANAN read a paper on the

PROGNOSIS IN PULMONARY TUBERCULOSIS.

The pulmonary infection is peculiar, affecting, as it does organs which lend them selves by structure, vascularity, mobility and communication with the exterior, to easy dissemination and secondary infections. The difficulties of prognosis are very great and the clinical course of the disease full of surprises. It was pointed out how dangerous it was to closely relate the pathological and clinical stages in forming a prognosis; and reference was made to the *post-mortem* proofs of the spontaneous curability of phthisis. The question of predisposition, acquired or hereditary, was discussed. In reference to the latter it was considered that evidence is gradually accruing in support of a less gloomy view being taken of the prognosis in such cases, and that an inherited predisposition is general rather than specific to tubercle. The value of physical signs was fully considered: cough, hæmoptysis, mixed infections, and complications. The value of constitutional symptoms as prognostic factors was discussed at length, with special reference to the temperature, nutrition and circulation. In reference to the duration and course of the disease, difficulties arose in obtaining the exact date of incidence. In conclusion he advocated that the prognosis in pulmonary tuberculosis should be based upon a careful study and estimation of (1) the general constitutional condition of the patient; (2) the effects of the disease upon the body temperature, nutrition and circulation; (3) a recognition of the extent of the lung involved and the ability of that left to carry on the respiratory process; (4) that the above are the important factors, and to them physical signs as they interpret local pathological "stages" of the morbid process occupy a subordinate position. Valuable as may be their diagnostic importance, they form an unreliable basis for prognosis.

Dr. NATHAN RAW said the virulence of the infection and the resisting power of the tissues, decided the fate of the person attacked. A predisposition to tuberculosis often made the prognosis unfavourable. Treatment commenced early and maintained under proper surroundings would of course favour arrest of the disease.

Dr. JOHN HAY said an opinion based upon the physical signs always underestimated the extent of the lesion. In forming an opinion as to the prognosis due consideration should always be given to the result of previous treatment.

Dr. John Hay, Dr. T. L. Glynn, Dr. Given, Dr. W. B. Warrington, Dr. J. Hill Abram, Dr. A. C. Wilson, Dr. W. B. Bennett, and Dr. O. Bowen, and Mr. Rushton Parker also took part in the discussions.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, April 23rd, 1905.

TREATMENT OF WHITLOW.

EVERY kind of acute inflammation of the fingers is called whitlow, says Prof. Reclus, whether it be seated in the skin, under the skin, in the sheaths of the tendons or in the bones. To each of these different situations corresponds a clinical variety and thus we have superficial whitlow or phlyctenular, which does not go beyond the papillæ of the derma. The subcutaneous whitlow can succeed the superficial form and was called shirt button whitlow by Velpeau. This variety is extremely painful, the patient is deprived of sleep and the slightest pressure on the part caused excruciating agony. The finger is swollen and of a dark red. The pulp is hard and remittent by distension of the pus, contrary to what is observed in other regions where fluctuation generally reveals the existence of purulent matter. The pulp of the healthy finger always presents a fluctuating sensation.

Whitlow of the sheaths of the tendons is quite as painful as the last variety and particularly grave, as the function of the organ is generally compromised; it is caused by direct inoculation, a penetrating wound, but it can also follow superficial inflammation, which by the lymphatics reach the sheaths. The infection, where the thumb or the little finger is affected, can be propagated to the palm of the hand; for the other fingers it is arrested at the base, as the sheaths terminate in culs de sac at the articulation of the phalanges with the metacarpal bones.

This kind of whitlow of the sheaths can become an osteo-periostic whitlow, but sometimes the whitlow is osteo-periostic from the beginning.

The causes of the four varieties of whitlow are almost always the same; inoculation of germs in the different tissues of the finger by small punctured wounds, produced by splinters of wood, rusty nails, etc.

When the slightest wound occurs in the finger, it should be washed in very warm water and plunged in a bath of 122°F., and this treatment continued if the finger shows signs of inflammation. However, if it becomes swollen, pulsatile and painful, whitlow has set in and the only treatment is that of the bistoury.

The operation is very painful as every one knows, and always superficial and incomplete when attempted without anæsthetics. Surgeons, however, do not care to employ chloroform for such a small operation and have tried local anæsthesia by means of refrigerating mixtures, ether or chloride of ethyle spray, ligature of the base of the finger with an elastic band, etc., but all these applications are of themselves more or less painful and do not remove the sensitiveness of the deep tissues.

This being the case, M. Reclus would not hesitate to employ chloroform if Stovaine as a local anæsthetic did not give marvellous results. His method of proceeding is as follows—with an ordinary subcutaneous syringe he injects a solution of half per cent, of Stovaine into the base of the finger under the skin and leaving the needle *in situ* he repeats the injection three or four times, until the skin whitens, then injects another syringe in the four sides of the finger so as to surround it with a kind of ring of the anæsthetic solution. In a few minutes the finger is rendered completely insensible and the operation can be done in the easiest manner, the patient looking on with the greatest composure if not with indifference. After the operation the finger is plunged for half an hour in a warm solution of oxygen water reduced to six volumes. After the bath an antiseptic ointment is applied, and the cure is complete in seven or eight days.

SEPTICÆMIA AND COLLARGOL.

Septicæmia is one of the frequent consequences of osteo-myelitis or phlegmon and is frequently fatal. Dr. Netter prescribes with remarkable results injections of collargol in one of the veins at the bend of the elbow. The fever falls considerably in twenty-four hours. He injects five centimetre cubes (one drachm) in the vein

after antiseptic treatment of the region, of a 2 per cent. solution of callargol.

PRESENTATION TO PROFESSOR LABBÉ.

Prof. Léon Labbé, member of the Institut and of the Académie de Médecine, was presented last week by former scholars with a medal struck in his honour by Patey. On the one side of the medal is a portrait, "serieuse et méditative," of M. Labbé himself, and on the other a scene inspired by an incident in the career of the popular surgeon. The medal was presented by Prof. Lannelongue, the president of the committee, in token of the high esteem in which he is held by those best acquainted with his sterling character.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, April 23rd, 1905.

At the Society for Innere Medizin, Hr. Lewin showed preparations from a

CASE OF AORTIC ANEURISM.

They were taken from a woman, æt. 60, who was admitted into the City Hospital Gitschinerstrasse, on February 2nd. Previously healthy, she had suffered for some time from cough and expectoration and hoarseness, and for about three weeks she had noticed a swelling in the neck, which, however, had caused no pain. Examination showed a tumour the size of the fist at the right sterno clavicum articulation, which was firm and which pulsated slightly. It caused slight dulness as far as the second intercostal space of the left side. The hands were cyanotic and the right arm was weaker than before. There was no pulse on the right side, nor in the brachial. The voice was husky and crowing on forced speech. The laryngoscope showed paralysis of the right recurrent nerve. A diagnosis of aortic aneurism was made. Possibly, also, it might be a tumour passing under the sternum. The patient died suddenly on February 8th. The autopsy showed that the tumour was a sac filled with organized thrombi. The dulness on the right was caused by a second aneurism on the arch of the aorta. The first aneurism corresponded to the innominate. The carotid was permeable, but the subclavian was not, the entrance into it being completely thrombosed. That the arm was still well nourished could only be explained by anastomosis between the internal mammary artery with the intercostals and the inferior thyroid with the superior.

PROSTATIC SECRETION AND PROSTATITIS—A CONTRIBUTION TO THE THEORY OF INFLAMMATION.

Hr. Rapaport said that it now had been shown that the secretion of the prostate might be characterised as a thin milk, a loading-up of an albuminous fluid with prostatic granules. Of these prostatic granules the only specific constituent was of a fatty body—a lecithin. It was known that an acute inflammation, in which there was pure pus, the specific character of the prostatic fluid was lost through disappearance of the lecithin granules. In chronic inflammation also these bodies were diminished in number; the most striking feature was the appearance of leucocytes, which were quite absent from normal prostatic fluid.

The speaker, under the direction of Professor Posner, had arrived at the result that the process of lecithin secretion took place through the glandular epithelium exactly as the secretion of fat took place in the mamma and other glands. The lecithin appeared in the epithelial cells, and thence passed into the lumen of the gland in drops. There was, therefore, no destruction of cast-off cell elements.

As to the retention of lecithin in chronic inflammation of the prostate, it was taken up by the leucocytes—therefore a true phagocytosis.

Hr. Posner said that in chronic prostatitis it was important to distinguish whether it was infectious or aseptic. In the latter case the leucocytes appeared with stasis of secretion and overpowered the unused material, and thrust it back into the lymph tracts, that it might be still useful to the organism. A

comparison of prostatic fluid with milk and colostrum threw light on the subject. Czary's view as to colostrum granules was now the general one—*viz.*, that at the end of pregnancy and immediately after delivery there was a stasis in the milk ducts that caused an immigration of leucocytes, and that they devoured the stored-up fat and that the fat formed the chief constituent of the granules. A similar process took place in the prostate. This explained how inflammation could be set up—the condition was a stasis of secretion with the result mentioned. We understood now why hypertrophy, for instance, was so often associated with chronic inflammation. The chronic inflammation was here, not the primary condition, the hypertrophy the secondary, but the reverse.

These researches shed a new light on treatment. We knew that occasionally in chronic prostatitis mechanical or physical treatment, massage, hydrotherapeutics or electricity had a rapid effect, whilst in other cases they failed. Their action was less due to the rapid emptying of the gland as in the raising of its muscular tone, so that the gland became capable of expelling its secretion. Hence the favourable effect in the atonic forms, and the failure in the infective ones. The speaker resumed: The lecithin was secreted by the epithelium and mixed with the contents of the gland. If the flow of the secretion was blocked an immigration of leucocytes took place and the leucocytes took up the lecithin. A proportion of the cases of chronic prostatitis depended solely on the blocking of secretion, and it was the form that afforded the best prospect of relief by mechanical treatment.

Hr. Benda said that the comparison of stasis in the prostate with colostrum was enlightening.

Hr. Fürbringer would not forget an old and proved method of diagnosis, the discovery of shreds of tubula from the prostate. He could confirm the occurrence of prostatitis without infection from his own experience.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, April 22nd, 1905.

PAGET'S DISEASE.

At the Gesellschaft, Lang brought forward a patient that Holzknecht showed to the meeting a year ago; this time, however, with a tumour over the morbid site. Lang said that he had treated the case with the Röntgen rays with very little success, and assured the meeting that the pathogenesis of the disease was very obscure. From his own investigations he had concluded that its genesis might correctly be described as *dermatosis epithelialis degenerativa circumscripta eccemiformis*. He found that the morbid accumulation of epithelia localised itself around the mamma and that the ecchymosis was the characteristic starting-point. The disease he recognised was most frequently met with in the mamma of females, although it was not confined to the sex, as the glans penis was sometimes affected. In the discussion Neumann confirmed the opinion that the morbid condition was a rare form of eczema rubrum, which was the typical shape it assumed on its first appearance. He might say that he had only seen two cases, which were both on the female breast, and a third that appeared on the glands in the form of a parchment-like thickening. The affection resembles an epithelioma more than a psoropormosis. The Röntgen rays he considered as the most likely therapeutic agent. Matzenauer thought that much more clinical observation was necessary before any dogmatic opinion could be given on the disease, as the affection persisted for years, while its characteristic histological results were yet very doubtful.

CHLOROFORM IN ACUTE UREMIA.

Hammer recorded the history of a uterine polypus, which, on attempting to remove, was necessary to narcotise with chloroform. Not long after commencing the administration the patient was attacked with asphyxia, which was rapidly followed with cramps, and in seven minutes later she died. The unexpected

phenomenon caused a closer examination to be made, and it was subsequently found that a morbid condition of acute uræmia was present.

LUXATIO FEMORIS.

At the meeting of Physical Medicine, Riedinger demonstrated a case of luxatio femoris of a congenital form above the acetabulum, which he described as the result of a hypoplasia of the pelvis *in utero*. The child he showed to the meeting was seven years of age, and had suffered from displacement of the right femur upwards since birth. He thought the example confirmed Holzmänn's theory of the foetal origin of luxation which had been supported by Hoffa, Lange and Schade, who all agreed that the hypoplasia of the skeleton was of intra-uterine origin, and that the deformity was mechanically introduced. He next related the method of reposition and the manner of reducing the hip-joint under such conditions by the bloodless form of surgery. He recounted nine cases he had treated in this manner. The first was a girl æt. 7½, left side dislocation which was replaced in October, 1901; by 1902 the patient was able to move about, having a slight inclination of the pelvis with the head of the bone inclined to turn out. Since then the patient has quite recovered and is now in a normal condition. The second case was also a girl, æt. 4½, with left femur dislocated. It was properly replaced on July 11th, 1902, and is now perfectly well. The third was a boy, æt. 4, with right dislocation, and was replaced in February, 1902, and is now well. The fourth was a boy, æt. 4½, with right displacement, which was replaced in July, 1903. This case is still under treatment, the head of the bone having an eccentric position owing to a rachitic widening of the acetabulum which is present on both sides of the pelvis. The functional result is fairly good in this case, although the knee is slightly bent. The fifth case, a female, æt. 2½, bilateral luxation, which was replaced three months ago and still held in that position by means of bandages. The sixth, a boy, æt. 4½, bilateral luxation, which had been replaced, the right having a concentric appearance and the left normal. The seventh, a girl, æt. 3½ with right displacement was corrected in July, 1903. Only in the first case were the bandages applied more than five months; in the others it was only necessary to fasten the lower part of the limb while the bandages were removed, the third month. In all his experience he had only one which had the dislocation repeated.

INFLUENCE OF TEMPERATURE ON THE GASTRIC FUNCTION.

Müller gave the Society a record of his experiments on the temperature of the stomach. The addition of food administered in a fluid form is rapidly corrected in the mouth and stomach, thus preserving a normal condition of the bowel. Half a litre of fluid administered, either hot or cold, would be corrected within six or nine minutes in the stomach. Cold was often the more dangerous, as the mouth was more instrumental in correcting extreme heats. He also found that the motor activity of the gastric organ was more impeded in action than temperate fluids, as the latter were rapidly absorbed into the system, while the former lingered long. Another point he added to his experiment was the acidity of the secretion, which was markedly absent in extreme temperatures, but present in moderate temperatures. Cold water and alcohol, however, produced an acid secretion, but cold water alone did not. He considered this an important point for tourists who could drink cold water with spirits as a protection against the introduction of germs into the bowel.

ON May 1st, a ball will be held at the Savoy Hotel, in aid of the Metropolitan Ear, Nose, and Throat Hospital.

At a meeting of the Ulster Medical Society held on April 13th, a letter having been read from Dr. Leonard Kidd with reference to the Direct Representation for Ireland on the General Medical Council, it was decided, after a long discussion, to take no action at present in the matter.

Operating Theatres.

GUY'S HOSPITAL.

OPERATION FOR IRREDUCIBLE SUB-CORACOID DISLOCATION OF THE HUMERUS.—Mr. ARBUTHNOT LANE operated on a patient who had dislocated the head of his left humerus forwards six days previously. He was a powerfully-built man, *æt.* 72, and showed evidence of considerable laceration of the soft parts and of hæmorrhage into them. Before he was admitted two attempts at reduction had been made without success; how much of the damage he had sustained was due to the original injury and how much to the attempts at reduction was problematical. After admission he was put under an anæsthetic and another attempt was made to reduce the head of the bone into the glenoid cavity, but again without success. Under these circumstances. Mr. Lane felt it was unwise to delay longer or to expose the man to further damage in attempts at reduction, he therefore made an incision through the front of the deltoid, and after considerable difficulty succeeded in levering the head of the bone back into its normal position; the muscles had sustained very considerable laceration, lumps of torn muscle lying almost free in the wound.

OPERATION FOR CHRONIC CONSTIPATION AND ITS RESULTS.—The same surgeon operated on a woman, *æt.* 35, who had all her life suffered from constipation, and who had been rendered miserable for some years by the consequences of the constipation. Her right kidney, which had been abnormally mobile, had been sewn up without relieving her of any of her unpleasant symptoms; her stomach had been exposed on another occasion, and some adhesions about the pylorus had been divided; this operation did her no good whatever. It had been proposed to perform gastro-enterostomy with the object of relieving her of her indigestion. She then came under Mr. Lane's care and he decided to relieve her of her constipation and of the symptoms consequent on it by dividing the ileum and establishing continuity of it with the termination of the big bowel. An incision was made in the left iliac region, through which the several viscera were exposed and examined; the cæcum had been displaced downwards and inwards so as to occupy the entire true pelvis; the lower portion of the small intestine was exceedingly wasted, its muscular wall being especially thin; it lay quite flaccid; the sigmoid was pinned down by adhesions to the iliac fossa in the manner already described. These adhesions were divided sufficiently to permit of the loop of sigmoid being drawn out from between the edges of the wound. The ileum was ligatured at two points about a couple of inches apart and about eight or ten inches from the cæcum; the portion of bowel between the ligatures was excised, while the ligatured ends of the bowel were buried by means of purse-string sutures; the proximal end of the bowel was made to open into the sigmoid, two continuous sutures being employed to effect this, the first one passing through all the coats of the bowel, the second only through the peritoneum and muscle. The abdomen was closed in the usual way. Mr. Lane said that the progress of these cases after the operation was excellent, provided the patient took reasonable pains to ensure a daily evacuation; should it be necessary to take same purgative after the bowel had been short circuited, this should be administered in the morning, so that the large intestine should be evacuated

before night-time; this obviates any back flow of material along the large bowel into the cæcum, as may occur should the small intestines empty their contents completely during recumbency at night-time. With reasonable care this should not, he remarked, be a source of trouble, but it is difficult he considered, to impress the importance of obtaining a daily evacuation on patients who have been accustomed to evacuate only once in three weeks. Should a back flow result owing to extreme carelessness on the part of the patient, the discomfort and pain which are consequent upon the loading up of the cæcum may justify the surgeon, he thought, in excising the large bowel as far as the splenic flexure; this procedure, he pointed out, does not entail anything but a very slight amount of risk and is comparatively a simple operation.

OPERATION FOR FRACTURE OF THE TIBIA AND FIBULA PRODUCED BY FORCIBLE AND EXCESSIVE ABDUCTION OF THE FOOT.—The same surgeon operated on a woman, *æt.* about 50, who had sustained a fracture of the tibia and fibula accompanied by very considerable displacement of the foot upwards and outwards; the fracture of the fibula was situated about six inches above its lower extremity, that of the tibia ran from above downwards and inwards, terminating at a point about an inch above the level of the astragaloid facet. She developed symptoms of delirium tremens very soon after the injury, and in spite of every precaution she drove the sharp end of the tibia through the skin. She came under Mr. Lane's care about four weeks after the receipt of the injury, the displacement of the foot then was such that she never could have used it for the purpose of locomotion. It was apparent that either the continuity of the fragments must be restored or the foot removed and an artificial limb substituted for it. The objection to the operation was the risk associated with the presence of a wound of the skin through which the fragment of the tibia projected in a more or less necrotic condition. The fibula fracture was exposed by a vertical incision over it, and the fragments which overlapped to the extent of nearly an inch and a half were separated from one another after the uniting callus had been cut through with bone forceps. A vertical incision was then made along the inner aspect of the leg and the tibial fracture exposed as fully as possible, the callus uniting the displaced fragments was divided by means of a chisel; it was only after the exercise of enormous force that the overlapping of the fragments was overcome; in doing this, however, the lower fragment of the tibia sustained considerable damage. The bones were retained in position by means of a screw which passed downwards, backwards and outwards through the tibia into the external malleolus. At this last stage the operation was one of very considerable difficulty, and the result obtained by it could not be perfect. If, however, Mr. Lane said, the operation had been performed soon after the receipt of the injury the difficulties experienced would have been comparatively trivial and the result must have been perfect. Operations for fractures in which the bones have united in bad position are, he considered, as difficult as any in surgery.

SUBJECT to the sanction of the Secretary of State, the Government of India has decided to establish an institute at Dehra Dun for use as a centre for the instruction of classes of medical officers and subordinates in the management of X-ray apparatus and as a depot or its storage and repair.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, APRIL 26, 1905.

GONOCOCCAL SEPTICÆMIA.

THE advance of pathological knowledge forces on us a wider view of the etiology of the septicæmic condition than that hitherto adopted. Septicæmia was formerly regarded as due in every case to one of a small group of organisms, those, namely, associated with ordinary suppurative processes. From time to time, however, it has been shown that many of the infections hitherto regarded as local cannot be so limited, and that the local lesions in these cases are, in fact, accompanied by a general septicæmia or bacteriæmia. Thus, typhoid fever is no longer regarded as a local disease, the intestinal lesion being only the seat of inoculation of a general infection. Similarly, even in diphtheria, whose systemic effects were for long supposed to be purely toxic, bacilli have been recently demonstrated in the circulating blood. Gonorrhœa, like diphtheria, we have been accustomed to regard as a typically local infection, but this view in the light of recent discovery will have to undergo modification. Several cases are now on record in which a definite general infection with gonococcus has occurred, manifesting itself by inflammations of the various serous membranes, pleuritis, pericarditis, and endocarditis in particular. That a gonococcal infection may give rise to most serious septicæmic or pyæmic conditions is shown by the series of cases published some weeks ago by Dr. Lynn, of Birmingham. (a) In all the cases the primary seat of infection was the urethra, and in the majority the urethritis was chronic. The secondary infections were very varied in nature, subcutaneous suppurations, purulent effusions into joints, disseminated visceral abscesses, and diffuse septic pneumonia being found in one or other of the cases. Although there was no doubt that the primary infection in each case was gonorrhœal in

(a) *Lancet*, Feb. 11th, 1905.

nature, yet rarely was the gonococcus found alone. The colon bacillus was the organism most commonly associated with it, and this is accounted for by the ease with which the colon bacillus can gain access to the urinary tract. The condition of gonorrhœal septicæmia is very liable to cause errors in diagnosis, as the gleet may be chronic and slight in amount, and its presence denied by the patient. It is well, then, in all cases of obscure pyæmic or septicæmic symptoms to make as careful a scrutiny of the urinary organs, as it is customary to do of the middle ear.

THE ALIENS BILL.

ONE of the boasts of this country has ever been that it provided a home and an asylum for the outcast from other countries, and certainly within bounds this principle has proved itself beneficial to the country as well as humane to the immigrant. The sturdy Huguenots who fled before the barbarous policy of their oppressors brought to this country an infusion of backbone and intelligence that has been of the highest value, whilst the Dutch who have settled over here have brought with them sterling qualities and have given rise to a strain in the stock from which their descendants are reaping rich benefits. New blood, then, so long as it is good blood, is not to be lightly disregarded, for the anthropological records of Britain show that the race who have built up an Empire without knowing it are no pure-bred blood-stock, like the hidalgos of Spain, but an admirable mixture of the good qualities of a great many races. With insular prejudice and an innate sense of superiority to foreigners, it is hardly a matter for wonder that aliens in general are disliked and despised, in spite of the catholicity of our laws with regard to immigration. That these same aliens, once they have accommodated themselves to their new entourage, form an addition to our national resources is a fact that has to be kept rigidly in mind in considering a question in which the obvious and natural objections seem to be all on one side. In the particular pressing alien problem that the Government are now attacking, however, intermixture by marriage and racial improvement are not immediate factors to be taken into account, as the aliens against whom so much feeling exists are chiefly Jews, and they prefer to remain an *imperium in imperio*, at any rate, till they rise in the social scale of their adopted country. These occurrences are comparatively rare, and the Jewish alien problem in the main must be dealt with as a matter involving the desirability or undesirability of entertaining in our midst an Oriental race, whose wish and practice is to remain separate and apart. No point of improving or derogating from the physical standard of the race in fact arises. Nor is it likely to benefit a nation for them to have in their ranks an industrious, hard-working temperate band of foreigners, who are content with very little, and who are notoriously amenable

to discipline? The answer must be in the affirmative, if qualified by the provisos that the individuals themselves shall not add to the dangers of life in the society they seek, or detract from the safeguards with which that life is hedged about. The criminal alien is a menace whom all good citizens will desire to see legislated out of their company, but medical men will take more, and particular, interest in his diseased *confreere*. A diseased person is not likely to be of much use to any society of individuals, and the humanity that would provide him with an asylum in our own hospitals and poor-law infirmaries has to reckon with the fact that his treatment must be conducted at the expense of our own sick, for whom funds and resources are by no means too abundant at any time. The Government will have the support of all medical men and hygienists in seeking to keep out the alien suffering from transmissible disease, even though some may feel that bodily infirmity should not debar a political or other refugee from the enjoyment of an asylum. The American Government have long ago decided to restrict the privilege of landing on their shores to those who are not likely to be a source of danger to themselves and others, and by their watchful immigration officers they annually exclude about 8,000 people, that is to say, about one per cent. of those who present themselves. Taking Mr. Akers-Douglas's figure of 80,000 as the number of aliens who annually seek a haven in Great Britain as correct, the exclusion of these "undesirables" would only amount to some 800 in all, if American experience be adopted as a guide, and this 800 includes both criminal and diseased. Keeping in mind the total number of immigrants, the exclusion of this paltry 800 could not be regarded as compromising in any way the principle of asylum, but it would undoubtedly make vastly for the well-being both of the "desirable" immigrants and of their neighbours. Opposition has been promised to the Bill, and, remembering the fate of last year's measure and that introduced by Lord Salisbury in 1894—though neither of these was as free from possible objections as the present bill—it is to be feared that it may fail to pass into law. From the medical point of view, the Bill, so far as it touches diseased persons, is much on a par with our present port regulations for inspecting ships and isolating any members of their companies found to be suffering from transmissible affections. These clauses, then, of the Bill are hygienic measures pure and simple, and as such it is difficult to see why they should not be adopted *con amore* by both sides. Trachoma is a disease as alien to these shores as the Russian Jew himself, and yet by his agency the affection is, we understand, spreading to children in all parts of London. The disease is a long and intractable one, which has necessitated special institutions for its treatment and great expense. To allow it to be imported freely is repugnant to common-sense, and our democratic American cousins will have none of it. Tuberculosis,

too, is common enough over here to make any unnecessary increase in its incidence sufficiently alarming, and the same is true of the venereal disease which is brought over wholesale by the rejected prostitutes from the Continent. Whatever opposition be opposed to the Bill, it is eminently desirable that the disease clauses should not be curtailed or abandoned.

MEDICINE AMONG THE ARABS.

HIS MAJESTY'S visit to Algeria has brought to the front the practice of medicine among that ancient people. The Arab has a great respect for the medical science of the *roumi* (Christian), for the curative art as practised by the natives is in great measure a matter of faith and the greater the sanctity of the doctor the better are his results. It must not be imagined that Arab doctors are all ignorant quacks whose hold on the confidence of the people is exclusively based on the Arab equivalent for Christian science. There are native schools of medicine where students repair for instruction and are austere maintained out of the public funds. At the termination of their studies, which consist principally in committing to memory passages from the Koran bearing on hygiene and in assimilating oral tradition, they then pass a sort of examination and are accorded a diploma in which it is set forth that the candidate is acquainted with "the certain sciences," such as the study of the four elements, and possesses a knowledge of the properties of drugs "for the purpose of producing violent or moderate effects." He is further certified to know the medicinal plants, under what circumstances to gather, and at what hour and in what way to administer them—which is possibly more than could be truthfully said of many young graduates of more civilised countries. He has learned by rote the names of the blood vessels and muscles "together with many other branches too numerous to be enumerated." In a country where every adult male who can afford it has three or four wives, it will readily be understood that the preparation of aphrodisiacs is an important source of income, and numerous are the prescriptions vaunted for the cure of the *beurd* (impotence). Organotherapy, which fell out of favour in Europe towards the end of the eighteenth century, is still in great repute among the Arabs and many tissues and secretions are employed therapeutically. To save trouble in arriving at a diagnosis, says Dr. Raynaud (*a*), they have recourse to a rule of thumb calculation based on the existence of four temperaments, corresponding to the four elements. To know the constitution of a patient all that it is necessary to do is to add together the letters of his name and that of his mother and divide by seven. The result indicates the star under which he was born, and, dividing the number by four, the patient falls into one or other of the four categories—fire, earth, air, or water. The

(a) "Etude sur l'Hygiene et la Medecine au Maroc," 1902.

appropriate treatment is then merely a matter of routine aided by memory. The fees are remarkably moderate, the average payment for a consultation, inclusive of medicine, being from four to two to four *flous* (a *flou* is the thirty-second part of a penny), but if the physician rejoice in an unusual reputation for sanctity the honorarium may be increased *ad valorem*. What we may call cosmetic medicine is an important branch of the art in Mahometan countries. Recipes abound for removing freckles and several effectual epilataries are known; for instance, a paste composed of quick lime, orpiment and soft soap; another, specially recommended, a mixture of nitre and ants' eggs (formic acid). Obesity is regarded as a quality instead of, as with us, a quasi-deformity, and to determine the production of fat, women swallow pills of arsenic and stuff themselves with bread crumb or *fenugrec*, a leguminosa with aromatic seeds. Perfumes of all kinds are greatly esteemed, both as cosmetics and therapeutically. Their views on gestation are peculiar. Among other oddities it is universally believed that a foetus may "go to sleep," that is to say, may cease to grow for a time, so that an Arab husband sees nothing extraordinary in his wife having given birth to a child after a year or two's absence. They do not divide the umbilical cord until the placenta has been expelled and the foetal end of the cord is charred in a candle flame. They attach great importance to the support of the perineum by means of a rolled-up towel, and an aromatic plaster is applied to the vulva after delivery. A belly band is applied for three days and the parturient is allowed to get up on the fourth or fifth day.

Notes on Current Topics.

Out-patient Organisation.

THE many attempts made by general practitioners to correct the abuses that prevail in the out-patient departments often seem futile, but it is encouraging to note that though many of the older hospitals seem to think that all is for the best in the best of all possible worlds, barring sufficient funds to carry on their work, still the newer hospitals and the newly constituted older hospitals are taking the matter in hand. Thus we note that the Belgrave Hospital for Children, in its new buildings and circumstances, is preparing to act in the matter in conjunction with the local practitioners. On April 8th, a meeting was arranged between the honorary staff and the doctors in the neighbourhood at which it was proposed that only a definite number of out-patients should be seen daily; that preference should be given to serious cases, and those sent up by doctors or governors; that, except in emergency, only cases resident within two miles of the hospital should be admitted. Various minor points were brought forward. The meeting, unfortunately, was not very well attended, but general good feeling was shown, it being recognised

that the hospital authorities were animated by a desire to make the hospital a means of usefulness to the district rather than to tout for funds under the pretence that more useful work was done within its doors than at any other institution. Before these suggestions can become operative, they have to be sanctioned by the Hospital Governors, and it may be hoped that they will join in the general wish that reason and sympathy, rather than ostentation and cant, should mark the career of the institution they serve. A remarkable suggestion was made at the meeting which shows the attitude of mind that prevails in certain quarters on the hospital question. This suggestion was that if an inquiry officer was found to be necessary, the general practitioners in the neighbourhood should subscribe to his salary. It is difficult adequately to characterise such a proposal without indulging in hyperbole.

Anthrax—an Accident.

A DECISION of the utmost importance was given in the House of Lords on the 14th of the month. The case in question was one in which a widow claimed damages from the owners of a carpet manufactory in Kidderminster for the loss of her husband, a workman in their employ, who had died of anthrax contracted through his occupation. The County Court judge of Worcestershire decided for the widow and awarded her £201 3s. 2d., as compensation. The Court of Appeal upheld the decision, and finally the case was carried to the House of Lords. The Lord Chancellor, in giving judgment said that it did not appear to him that by calling the consequences of an accident a disease, we altered the nature of the consequential results of the injury that had been inflicted. A workman, in the course of his employment, might spill some acid on his hand and thereby cause an injury that might lead to erysipelas—a definite disease; some trifling injury by a needle sets up tetanus. Were these not within the Act? because the immediate injury was not perceptible until it showed itself in some morbid change in the human body, which, when shown, was called a disease? He could not think so. He was therefore of opinion that the County Court judge was right. Lords Lindley and Macnaghten concurred, and Lord Robertson dissented. The appeal was, therefore, dismissed. Law and medicine are so essentially opposed, in the present state of our knowledge, at least, that it is not a matter for wonder that lawyers are constantly contradicting each other when medical points are in dispute. A case occurred some years ago in which a medical man brought a claim against an accident company because he had contracted a chancre of the finger through an accidental wound, whilst attending a syphilitic woman in her confinement. The judge decided that syphilis, being a disease, it could not be regarded as an accident. Hernia, too, has been decided both to be and not to be an accident—if we remember rightly. The distinction, of course, between disease and accident

is one that the lawyers must settle for themselves, as medicine regards it as under an "accident" for a doctor, say, to catch scarlet fever from a patient as to get septicæmia through dressing a suppurating wound. Either of them may be the result of the action of unforeseen occurrences. The present decision, coming from the House of Lords, will affect the accident assurance companies materially.

"Medical Notes and Queries."

ONE of the axioms of competitive existence is that there is always room for a good thing, and although the field of medical journalism might be thought to be already well occupied with the existing publications, we have no doubt that a niche may be found for a new competitor for favour that has just made its bow to the public. This new journal is called *Medical Notes and Queries*, and it aims at fulfilling for the medical world much the place that *Notes and Queries* has long filled in another sphere. *Medical Notes and Queries*, although published in America, hopes to find a circle of readers over here who will thus be kept in touch to a certain extent with the kind of medical opinion in the United States. The editor is Dr. Henry W. Cattell, whose name is well-known on both sides of the Atlantic as having for several years edited *International Clinics*, for Messrs. Lippincott and Company, and much of the success that attended the publication of that quarterly was due to his zeal, discrimination, and journalistic instinct. *Medical Notes and Queries* is only to appear ten times a year, and it looks for literary support to those who have rare and out-of-the-way phenomena to record, or who wish through its medium to obtain information on obscure questions and puzzles. We have now seen three numbers, and we can say without hesitation that if the standard of interest be maintained, as there is every reason that it should be, this little publication is sure of a warm welcome. With its modest subscription, only one dollar a year, its elegant get-up, and its unique aim, we feel there is little doubt as to its acceptability in the quarters to which it appeals.

Antagonism Between Bacteria.

ONE of the most interesting branches of bacteriology is that dealing with the mutual relations of pathogenic bacteria. It is well known, though the subject has by no means received the study it deserves, that the presence of a secondary infection may add virulence to an infection previously comparatively innocent, or, in other words, that the products of one species of organism may increase the activity of another species. There has been so far, however, but little attention paid to the contrary phenomenon, but it is true, also, that the presence of certain bacteria detracts from the virulence of others, or even prevents their growth. Thus it has been recently pointed out that two such common organisms as *Bacillus coli* and *Bacillus pyogenes*, each distinctly patho-

genic, are mutually destructive, and this action takes place either in culture or *in vivo*. It has been stated, too, that tubercle and typhoid are incompatible diseases, and though the clinical evidence, either for or against, has never been marshalled, it is not impossible that there may be antagonism between the causative bacteria of the two diseases. Metchnikoff has devoted some attention to this subject of bacterial antagonism, and has discovered certain points which may turn out to be of practical importance. Thus the *Bacillus subtilis*, a widely-distributed non-pathogenic bacterium, is found to have a weakening action on the toxins of tetanus, and the typhoid bacillus destroys the toxins of diphtheria. Moreover, the lactic acid bacillus, an organism which has been long held in disrepute, is declared by Metchnikoff to be one of our greatest benefactors. It has an antagonistic action to the putrefactive bacteria which swarm in the human intestines, and are responsible for the auto-intoxication consequent on the absorption of their products. Metchnikoff is a believer in the doctrine that the decrepitude of old age is a result of the continued absorption of such toxins, and he mentions that natives of Bulgaria, who are notably long lived, are in the habit of drinking large quantities of sour milk. Apart, however, from the question of old age, many clinical observers are aware of the therapeutic action of buttermilk in various enteritic and gastro-enteritic conditions. For this action a rational basis is now discovered in the presence of large numbers of lactic acid bacilli.

Cerebro-Spinal Meningitis.

THE fact that a case of cerebro-spinal meningitis has recently been reported in this country, and the possibility that others may follow in its wake, makes the experience of American physicians, who have had much experience in the treatment of this disease, of exceptional interest. All such seem to agree that the first step to take is to draw off the excess of cerebro-spinal fluid that results from the invasion of the nervous system by the *diplococcus intracellularis*, for not only is this procedure if accomplished aseptically free from danger, but if the fluid be all thoroughly drained off the acute symptoms are markedly relieved. This treatment is thoroughly well comprehensible on rational grounds, but the subsequent step that is advised is so extraordinary that it can only be considered as purely empirical. This step is the injection of diphtheritic antitoxin. It was first advised by Dr. Wolff, bacteriologist to the Hartford Board of Health, and it has been subsequently practised by Dr. Waitzfelder with very promising results. Dr. Wolff's own experience we have not been able to trace in full, but Dr. Waitzfelder has used it in seventeen cases, five of whom are now well, five were progressing favourably at the time of writing, three had died, and four seemed likely to do so too. Still, ten recoveries from so acute a condition as cerebro-

spinal meningitis is an encouraging step, and we hope to hear more of the treatment when it has been longer on trial. The method has found its way to Boston, and is now in vogue in the three leading hospitals there. Although in the present state of our knowledge of antitoxins it is difficult to see how any good can result from this injection, it is at least not irrational to suppose that the serum may contain some body of which we are ignorant, but which may be of specific value. In America they have far larger opportunities of studying the disease than, fortunately, we do over here, so that in the event of further cases breaking out, the best we are likely to do for our patients is to treat them on American lines.

American Medicine from a Chinese Point of View.

AN interesting view of American medicine from a detached standpoint is to be found in a volume entitled "As a Chinaman Saw Us." Whether the work be really that of a foreigner, or merely the pose of a clever literary man, it is sufficiently interesting as giving the impressions an intelligent Celestial might receive in studying the society of the great Commonwealth. The point that chiefly appeals to him in regard to medicine is the contrast between the regular physicians of the better class, and the horde of quacks and mountebanks of all sorts, who prey on the credulity of the people. "America has a body of physicians and surgeons who are a credit to the world, modest, conscientious, and with a high sense of honour, but they are as dragon's teeth in a multitude of the so-called 'quacks' who take the money of the masses and prey on them, protected in many cases by law. No one profession demonstrates the abject credulity of the great mass of Americans as that of medicine." "In no land under the sun are there so many ignorant, blatant fakirs preying on the people, and in no land do you find so credulous a throng as in America, yet claiming to represent the cream of the intelligence of the world." This credulity, which we think may rightly be imputed to the Americans, and, in a lesser degree, to our own people, is certainly a curious feature in an advanced civilisation. The Chinaman draws attention to one point in which he thinks Chinese practice is in advance of American, in that the aim of the former is preventive, of the latter curative. "The best way to cure is to watch the patient and keep him well, or prevent him from being taken sick."

Consultations by Telephone.

LIKE all good things, the invention of the telephone has drawbacks which go a good way to balance the undoubted convenience of being able to speak to persons at a distance without much more trouble than is involved in ringing a bell and holding an instrument to the ear. Few and happy are the doctors who can afford to be without

the telephone! The few quiet moments for meals and reading are for them not harassed by the crackling of shrill electric bells and reiterated demands to know if they are there. Inconvenient callers can at least be kept at bay by means of a servant who lends herself to conventional prevarications, and the silence of night can only be disturbed by the euphonious warnings of the night-bell. But the telephone has no mercy, and its subscribers, one suspects, no conscience, especially now that the penny-call is being replaced by a lump-sum subscription. Moreover, the telephone is becoming a serious menace to earning-power, for there are not a few who find its facilities an excellent short-cut to cheap advice. It is very difficult to know how to charge a patient who rings up at dinner-time to say he is ailing with much the symptoms as he had three months ago, and shall he take the same medicine? Or he who doesn't think it worth while asking the doctor to come, but Jenny has got the measles—they know because some other girls at her school have it—and would it be worth while giving her some ipecacuanha wine for her cough, and, if so, how much? People of this type do not see that they are adding the insult of making their own diagnosis to the injury of doing the doctor out of his fee, and they find refuge in the pseudo-humanitarian plea that "they are sure the doctor is tired after his round, and it would be a pity to make him come to see them." At this rate of progression there would soon be nothing left to tire the doctor except the ringing of the telephone-bell. It would be well that doctors should let people know that they are available for consultation by telephone; that their fee for such consultation is a fixed figure; and that all advice obtained by its aid is booked as a visit. Discretion could relax the charge in individual cases in which it pressed unduly harshly.

The Channels of Elimination of Bacteria.

IT is of great importance to the public health that the physician should thoroughly understand the channels by which the infective organisms of the different diseases leave the body. An attention to this detail in every case of infectious disease would do so much to prevent its spread. In the case of phthisis much has been done to instruct the public as to the necessity of destroying the *contagium vivum* contained in the sputum, and most medical men are fully awake to the necessity of instructing their patients on this point. In the case of very few other diseases, however, has due attention been paid to the necessity of sterilising infected excreta. It is true that in typhoid fever, it is usual to adopt some means of destroying the infectivity of the faeces, but very seldom are similar measures devoted to the urine. Nevertheless, in a large proportion of cases, and for a continued period after convalescence, the urine contains active typhoid bacteria. In many diseases such as diphtheria, pneumonia, whooping-cough, streptococcal infections, it is probable that a considerable extent

of the respiratory and pharyngeal surfaces are infected, and consequently the excretions from these regions may prove a source of danger. With regard to the passage of bacteria through the skin, it is curious how little is known. For long it has been held that the flakes of epidermis in the desquamation stage of scarlatina are capable of conveying infection, but the evidence for this is of the slightest. In fact it is doubtful whether in any condition the bacteria of disease are excreted in the secretions of the skin, unless we regard the special case of tubercle in milk. It is interesting to note that the above points were discussed in 1890 by Dr. Walsh in a little work entitled "Excretory Irritation."

Railway Accidents and Litigation in the States.

It is of some interest to contrast the conditions and abuses of actions for personal damages taken against railway companies in these countries and in America, and the paper contributed by Dr. Punter, a medical referee of wide experience in this class of cases, to a recent number of the *Medical Record* may be taken as representing an enlightened view of the conditions observed by him in New York. According to him, the greatest injury to justice arises from the activity of "switches," or speculating lawyers of the worst class. When any railway accident occurs, these persons gather like vultures on the prey, and almost force their services on the more or less suffering victims. They are usually in league with medical men of the baser sort, who are ready to appear in the witness box with whatever "expert testimony" may be desired. These conditions, however, would not of themselves amount to a serious hindrance to justice, were it not for the general ignorance of all medical matters displayed by the lawyers. It is, of course, impossible to expect technical knowledge of such matters from a practising lawyer, but it is always open to him to keep himself advised by someone who possesses the necessary knowledge. Indeed, in some cases the innocence displayed by American lawyers in medical matters seems to rival that shown by judges of the High Court in this country regarding all subjects outside the immediate purview of the Bench, as, for instance, in one case mentioned by Dr. Punter, when a clever lawyer was silenced by a quack declaring that the plaintiff suffered from "traumatic injury, with general results."

Plague and Pediculi.

THE rôle of such suctorial insects as the mosquito in the dissemination of certain specific infectious diseases has now been fully demonstrated. The scientific proof of the existence of the malarial parasite within the body of the mosquito is one of the triumphs of modern medicine. The carrying-power of flies with regard to the bacillus of typhoid fever is also an acknowledged fact. In the case of plague, it has been

shown by Hankin, Ogata, and others that the disease may be spread through the agency of the common rat-flea. It is doubtful, however, if the flea bears quite the same relation to plague that the mosquito does to malarial fever, for some authorities rather consider this class of vermin as *fomites*. That pediculi may, under certain conditions, be responsible for the spread of plague appears highly probable from the observations of Dr. Maximilian Herzog, pathologist in the Government Laboratories at Manila, P.I. This gentleman has described a case of bubonic plague occurring in a girl of nine, whose scalp and body were literally infested with pediculi, having been grossly neglected for some time. The case was a fatal one, but before the body was opened for the *post-mortem* examination three pediculi were seized with sterile forceps and dropped into culture-tubes containing slightly alkaline bouillon. Typical cultures of plague bacilli were developed, and the bacteria were afterwards identified as *B. pestis*. Histologically, the bacilli were also isolated from the buboes and they were also present in the inflammatory tissue around the Malpighian bodies of the kidneys. It is not difficult, after reading the account of this case, to conceive the possibility of other individuals becoming infected with the disease, should one of these pediculi have gained access to their person.

Money and Bacteria.

Few people are likely to agree with an American investigator who regards the handling of money as a danger to public health, and even those who give a theoretic assent are not likely to allow their belief to influence their desires. It is, however, obvious to everyone that money passing from hand to hand must carry with it a rich bacterial flora, and must to a certain extent expose the recipient to infection. It is of some interest, then, to know what tokens we may handle with greatest safety, even if the knowledge does not deter us from touching the more dangerous. That it will not, we fear, is to be admitted, since it is found that copper money most nearly approaches sterility, while paper money affords the richest soil for bacterial growth. In experiments performed by Dr. William Park, of the New York Board of Health, it was found that diphtheria bacilli could be recovered from a previously sterile bill as long as one month after they had been introduced to it. On the other hand, pennies introduced to the mouths of children suffering from diphtheria were found twenty-four hours later to be sterile. Moreover, when a culture of colon bacillus was sprayed on copper coins three hours later no living bacteria were to be found. There appears to be no doubt that the metal of coins, and particularly copper, has some bactericidal action. Dr. Park does not seem to have included gold coins in his investigations, so that our readers will probably hope that gold has similar powers to those of the inferior metal. And while we do not counsel a refusal to accept

five-pound notes lest they should harbour hostile germs, we can advise our readers where they have the choice, to take clean rather than soiled paper money.

Practical Joking.

THE effect of fright or some violent mental emotion in producing functional disease of the nervous system is well known. How many children are there not suffering from chorea whose parents persistently ascribe the disease to the traditional "black dog jumping up at them," or to some similar terrifying apparition! Certain cutaneous disorders, such as alopecia areata and lichen planus, are prone to appear after a severe mental shock. Many other systems of the body are unfavourably affected by stimuli of this sort, and there can be little doubt that fear actually lowers the physical power of resistance to disease. There are some sensitive souls who cannot endure teasing of any sort or description. The childhood of such is often rendered miserable owing to the constant dread which they experience of something being done to them by their playfellows. As for what is usually called practical joking, no one would dare to try it on with these timid children, lest they should go out of their minds. A joke can certainly be carried too far, and in over-excitability, neurotic individuals the effects of such brutal pleasure—which is only exquisite torture to those upon whom it is perpetrated—may be very serious indeed. An unfortunate case of this character has recently been reported from Paris, in which a man, wishing to frighten his wife, dressed up an image of himself in wax, with easily detachable limbs and head, and placed it in bed. The poor woman's fright on taking the figure of her husband for the reality was so great that she became acutely maniacal from that moment, and had to be conveyed to an asylum. The husband, on realising what he had done, then committed suicide out of remorse by swallowing a corrosive poison.

Anatomical Bicycle Pedals.

It has probably occurred to many of our readers that the usual shape of bicycle pedals is unnatural, and unsuited to the easy position of the feet. When the feet are held comfortably some five or six inches apart, one finds that the toes point slightly outwards, and that the outer borders of the soles are at a slightly higher level than the inner. It is obvious that if bicycle pedals are to be thoroughly comfortable, they should be so arranged as to suit this natural position of the feet. In order to do this, all that is necessary is that they should be set at a slightly oblique inclination to the horizontal instead of, as at present, horizontally. A medical man, Dr. Lundie, of Edinburgh, has recently devised a form of pedal which answers these requirements, and he finds it much more comfortable than the ordinary form. There is less chance of slipping and losing the pedal when it is set obliquely, and

the usual tab at its outer end is rendered unnecessary. Many of our cycling readers and their patients have probably found themselves suffering from corns along the outer border of the foot, at points where it is difficult to account for any pressure. The cause in these cases is, in reality, the pressure of the side of the boot rendered necessary by the flat pedal, and it is entirely abolished by the use of sloping pedals.

PERSONAL.

By the retirement of Surgeon-General Sir Edmond Townsend, K.C.B., the Army Medical Staff loses one of its most notable members. Sir Edmond entered the Army in 1867, and for the past thirty years has taken a share in our numerous little and big wars, in Abyssinia, Zululand, Egypt, Burmah, Ashanti, India, and South Africa. As principal medical officer to the 1st Division of the Tirah Expeditionary Force, he was present at the capture of the Samapaga and Arhanga Passes, participating later in the operations in Bazah Valley, and he held a similar position throughout the whole of the recent campaign against the Boers. Sir Edmond was promoted to the rank of Surgeon-General in September, 1901, and honoured with the military K.C.B. last year.

EARL CAWDOR has consented to become the President of the West Wales Sanatorium Committee.

DR. E. SYMES THOMPSON, Gresham Professor of Medicine, will deliver a course of four lectures at Gresham College, Basinghall Street, London, on May 2nd, and three following days at 6 p.m., the subject being the "Evolution and Degeneration of the Teeth." These lectures are free to the public.

WE hear that a generous gift has just been made by Madame Emile Zola. She has offered the Assistance Publique her property of Medan, which, under the name of the Emile Zola Foundation, will be carried on as a convalescent home for members of the female staff of the Assistance.

THE Emperor of Austria and the Imperial Family have supplied the nucleus of a fund for the erection of a special building for the benefit of sufferers from lupus vulgaris.

THE Bisset Hawkins medal has been awarded to Sir Patrick Manson.

THE Copenhagen gold medal offered for an essay on Colour Blindness has been awarded to Dr. Henning Chr. Trappaud Rønne.

ALDERMAN S. E. JOHNSON, L.S.A. Lond., L.R.C.S. Ed. has been enrolled on the Commission of the peace for Worcester.

DR. and Mrs. Alan Philips, who have spent the last twenty years of their lives in Boulogne, were last week presented by the members of the English colony there with a massive silver salver and a purse of gold in commemoration of the celebration of their silver wedding.

THE name of Mr. George Jackson, F.R.C.S., Direct Representative on the General Medical Council, has been placed upon the Commission of the peace for Plymouth.

DRS. DUTTON and Cookson, of the Liverpool School of Tropical Medicine, state that of nearly 40,000 deaths from sleeping sickness in Uganda, only 244 occurred inland.

Special Correspondence.

[FROM OUR SPECIAL CORRESPONDENT.]

SCOTLAND.

THE LATE SIR JOHN SIBBALD.—The death was announced on April 20th of Sir John Sibbald, M.D., F.R.C.P.Ed., who retired under the age limit from the position of Commissioner in Lunacy, which he had held for twenty-one years, in 1899. He had for some months been suffering from malignant disease of the tonsil, of a nature to preclude hope of relief. Sir John Sibbald was born in Edinburgh in 1833, and was educated at Merchiston Castle and the University of his native town, where he graduated M.D. in 1851. As an undergraduate he had the unusual distinction of being elected President of the Royal Medical Society, and after taking his degree was a house surgeon in Perth Infirmary. Thereafter he studied in Paris, and then turned his attention to that branch of medical science of which he was latterly so distinguished an ornament—mental diseases—by becoming an assistant physician in Morningside Asylum. His subsequent studies under Griesinger of Berlin, at that time the greatest authority in Europe, imbued his mind with the idea which dominated his work during the rest of his life—that insanity is only a part of general nervous diseases and cannot be treated apart from them. In 1862 Sibbald was appointed superintendent of the Argyll Asylum, and there showed the progressive bent of his mind by abolishing what were called "airing courts"—small enclosed spaces with high walls in which troublesome patients were kept for a part of each day. He was the first to see the evils of the system, with the result that as the patients had to be employed on ordinary outdoor labour they suffered less from phthisis, and in the sequel his example was speedily followed by the other Scottish Asylums. In 1870 he was appointed Deputy Commissioner and in 1878 Commissioner in Lunacy. As Deputy Commissioner he had great experience in the home treatment of the milder forms of imbecility and insanity which had been reorganised in Scotland by Sir Arthur Mitchell. The interest thus excited in his mind in the home care of the insane continued up to the time of his death, and only last year the meeting in Edinburgh of the International Home Relief Congress was largely due to his initiation. In succeeding Sir Jas. Coxe as Commissioner he threw himself with extraordinary conscientiousness and thoroughness into every movement for the good of the insane, and after his retirement from official work he took a leading part in the agitation in favour of the hospital care of minor forms of mental disorder and "borderland" cases. Though not a prolific writer, Sir John Sibbald's published work was characterised by the same painstaking thoroughness and minute attention to detail as all his other activities. For a time, in his early days, he was attached to the staff of the *Lancet*, and latterly edited the *Journal of Mental Science*. He wrote a volume on "Insanity in its Public Aspect," in which his matured experience as an asylum superintendent and Lunacy Commissioner was given to the profession. Most of his writings dealt rather with the administration than with the clinical aspects of his subject, as the titles of the following of his works show: "Lunacy Administration in Berlin and Scotland," "Gheel and Cottage Asylums," "Plans of Modern Asylums." He contended in a paper read before the Statistical Society, which has since attracted considerable discussion, that suicide was not increasing in Great Britain. In 1877 he was the Morison Lecturer to the Royal College of Physicians. On his retirement from public life in 1899 he was knighted, but did not cease to interest himself in lunacy matters. He became medical adviser to the Edinburgh District Lunacy Board, and held the position until last year, when the building of the Bangour Asylum was so far advanced as to admit of a superintendent being appointed. It was due to his initiative that the village asylum plan was adopted, and his efforts were always directed to hasten its erection and keeping down expenditure. He had the gratification

of seeing the Aberdeen Village Asylum built within four years of the purchase of the site at a cost much below that of any asylum of the older type, and this to some extent compensated for the disappointment which the delays in connection with Bangour caused. Sir John Sibbald was a leading Fellow of the College of Physicians and had been on the Council for some years. He was a man of wide reading and attainments, who yet devoted his mind almost exclusively to his speciality. Kindly and courteous to all, strong and not readily influenced by others, and entirely free from self-seeking in his acts, he was a man who had no enemies or detractors, but was universally liked and respected throughout Scotland. He is survived by a widow and four children.

GLASGOW UNIVERSITY GRADUATION CEREMONY.—The spring "capping" took place in Glasgow on April 18th, when a number of honorary degrees were conferred. Among those who received the honour of LL.D. degrees were Professor Crum Brown, Edinburgh, and Sir William Whitt. The proceedings were marred by a certain amount of disturbance on the part of the students; not, as would seem from the published reports, of a particularly reprehensible nature as these things go, but sufficient to induce reprisals on the part of the Rev. Vice-Chancellor, who concluded the proceedings summarily by saying, "I had intended to say a few words at the close of the session, but I have too much respect for the senate and myself to give an opportunity for the renewal of the howling disturbances and gross discourtesies with which we have been treated to-day. I say nothing." It is, of course, to be deplored that the students should not behave quietly at University ceremonials, but at the other universities this recurrent friction between them and their Principals does not arise. Principal Story would, it seems to us, show more self-respect, and would better maintain his dignity if he did not yield to these outbursts of bad temper—besides, the knowledge that he is one whom it is the easiest thing in the world to "draw" is just what causes a certain section of the undergraduates to indulge in the gentle sport of "baiting the Principal."

ASSISTANT MEDICAL OFFICER OF HEALTH FOR GLASGOW.—The following gentlemen were nominated for the above post at a meeting of the Health Committee of the Glasgow Corporation:—Dr. Andrew Love, senior resident physician at Belvidere Hospital; Dr. G. N. Wilson, M.D., D.P.H., assistant to the Medical Officer of Health, Aberdeen; Dr. William Wright, M.B., D.P.H., interim Medical Officer of the Port Local Authority of Glasgow; and Dr. Thomas Adam, assistant bacteriologist of the City. The names having been voted upon by the members of Committee, Dr. William Wright received eight votes and Dr. Wilson six votes. Dr. Wright was therefore recommended for the position.

REQUEST TO GLASGOW ROYAL INFIRMARY.—The late Mr. John Gilmour of Mount Vernon Row, Gareloch, has bequeathed in his will the sum of £3,000 to the above hospital. The reconstruction scheme of this hospital is still in abeyance.

Correspondence.

THE ASSOCIATION OF MEDICAL DIPLOMATES OF SCOTLAND.—AN APPEAL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—At the recent successful dinner of the Association in London, one of the desired reforms referred to by Dr. David Walsh in his speech was that of the substitution of the title of member for that of licentiate. I venture to think that Dr. Walsh indeed echoed the voices of all licentiates in this matter. There exists already a membership of the Royal College of Physicians which is only obtainable after a further and stiff examination, but no such similar diploma of member is granted with or without examination by either the Royal College of Surgeons or the Faculty of Physicians and Surgeons of Glasgow, so that the change desired, of membership in lieu of licentiate, would not interfere with any existing diploma-examination or title.

The question at once arises how and by what channel are we to approach the colleges to obtain this much-desired change of title? The Royal Colleges have shown marked sympathy with, and interest in, the formation of our Association; a gown has already been granted, and it seems not unreasonable to suppose that if the Association could approach the colleges, backed by the support of all its diplomates, every consideration would be given to what appears to us all to be a just and reasonable request.

The very large number of Scottish diplomates practising in London alone should furnish a big membership list. There are many more diplomates in the provinces, and the object of this letter is to appeal to all to at once take up their membership of S.M.D. Association, every Scotch diplomate should join at once, a big membership list is necessary if we are to hope to attain our desires.

I should like to propose the appointment of county secretaries throughout England to get into touch with all fellow diplomates and organise for the above and all the objects of our Association. I am sure the hon. sec., Dr. David Walsh, 18A, Hanover Street, London, would be glad to receive the names of any diplomates willing to help in that or any other way.

I am, Sir, yours truly,

T. W. BARTLETT,

L.R.C.P., L.R.C.S., L.F.P.S.G.

Steeple Bumpstead, North Essex.

[The suggestion of Mr. Bartlett appears to be sound and practical. On general principles anything that tends to organise the medical profession is deserving of cordial support.—ED.]

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

Sir,—As a licentiate of the Royal College of Surgeons of Edinburgh I venture to write a line in favour of the above Association. Although the Society is young, it has already achieved much. It has for the first time in history given a rallying point to the holders of a Scotch medical or surgical diploma who practice outside Scotland. It has secured a magnificent roll of vice-presidents. It has presumably obtained a gown for the licentiates R.C.S.

Now, sir, there are some 5,588 Scotch diplomates in practice in the United Kingdom, of whom about 1,060 reside in Scotland. The main body of the licentiates, therefore, is to be found in Great Britain and Ireland. As a matter of fact, there are about 830 in London, 3,240 in the rest of England, 300 in Wales, and 500 in Ireland. These members represent vast payments to the Scotch colleges. We have no reason to complain that the colleges have not been fair to their diplomates. Indeed, their attitude in the past has always been fair and sympathetic, so far as they have had an opportunity of gauging the wants and wishes of their former *alumni*. Now, the Association has come forward as an intermediary between the colleges and their diplomates. Clearly it is the bounden duty of every diplomate of a Scotch college to join the Association forthwith.

I am, Sir, yours truly,

L.R.C.P., Edin.

Obituary.

REGINALD BIGG, M.R.C.S. AND P.LOND.,
M.B., B.S. DUR.

WE regret to announce the death of Dr. Reginald Bigg, resident medical officer of Newcastle Dispensary. The deceased who was only about twenty-nine years of age, had been unwell for the last three weeks, and died at the residence of his friend, Dr. Murray, of Heaton. Dr. Bigg was a native of Oxford, and qualified for his profession at London, and took his degree in Durham. Previous to his appointment—two years since—he was assistant visiting medical officer. He was also connected with the college of medicine. He won the golden opinions of the Governors of the Dispensary,

and the high regard of many poor patients attending the institution, for his ability and kindness of disposition.

THOMAS MORTON, M.D.LOND., M.R.C.S.ENG.,
L.S.A.

DR. THOMAS MORTON died recently at Kilburn, London, N.W., after a short illness. He was born at Holbeach in Lincolnshire in November, 1836, his father being the Rev. James Morton, vicar of Holbeach and prebendary of Lincoln. In 1854 he entered at Queen's College, Cambridge, and matriculated at the University of London and entered at King's College in 1858, gaining a Warneford entrance scholarship. In 1862 he obtained the diplomas of M.R.C.S.Eng. and L.S.A. and graduated M.B.Lond., later taking the M.D. degree in 1865. Dr. Morton was one of the founders of the Kilburn Provident Medical Institute about 1874, and his prolonged services with it were recognised by his being elected chairman and consulting medical officer.

EDWIN THOMAS TRUMAN, M.R.C.S.ENG.

MR. EDWIN THOMAS TRUMAN, who died on April 8th at the age of eighty-six years, held for over half a century the position of dentist to the Royal Household. His name is more widely known in connection with matters outside his profession. The first Atlantic cable in 1858 failed owing to want of perfect and durable insulation, due to the fact that gutta-percha used as the protective covering could not at that time be thoroughly purified. Mr. Truman discovered a method by which gutta-percha could be prepared in any quantity by purely mechanical means without injury to the material. The patent of the discovery was disposed of to the gutta-percha company who made the cable for the Atlantic Telegraph Company.

GEORG MEISSNER, M.D.

DR. GEORG MEISSNER, formerly professor of physiology in the University of Göttingen, died recently at the age of seventy-five years. His name is well-known in connection with the "tactile corpuscles."

NEW BOOKS AND NEW EDITIONS.

We have received the following since publishing our last list:—

- THE AMALGAMATED PRESS, LTD., AND THOMAS NELSON AND SONS (London).
The Harnsworth Encyclopædia. Illustrated. Parts I., II., and III. Pp. 160 each. Price 7s.
- J. W. ARROWSMITH (Bristol).
Medical Philology. Gathered by L. M. Griffiths, M.R.C.S. Part I. A—Ed. Pp. 100. Price 2s. 6d. net.
- BAILLIÈRE, TINDALL AND COX (London).
The Conjunctiva in Health and Disease. By N. Bishop Harman, M.A., M.B., F.R.C.S. Illustrated. Pp. 276. Price 10s. 6d. net.
Surface Anatomy. By T. Gillman Moorhead, M.D., M.R.C.P. Illustrated. Pp. 150. Price 4s. 6d. net.
Clinical Lectures on Appendicitis, Radical Cure of Inguinal Hernia and Perforating Gastric Ulcer. By G. R. Turner, F.R.C.S. Pp. 136. Price 5s. net.
Elementary Microscopy. A Handbook for Beginners. By F. Shillington Scales, F.R.M.S. Illustrated. Pp. 179. Price 3s. net.
Lectures on Clinical Surgery. By H. C. Hinder, M.B., M.Ch. Illustrated. Pp. 286. Price 12s. 6d. net.
- JOHN BALE, SONS AND DANIELSSON, LTD. (London).
What Venereal Diseases Mean and How to Prevent Them. By Prof. Eriks Poutoppidan. Pp. 79. Price 2s. net.
- E. H. BLANKLEY (London).
The Diagnosis and Treatment of Some of the Common Diseases of the Rectum and Anus. By Cecil H. Leat, M.A., M.B., F.R.C.S. Pp. 118. Price 2s. 6d.
- J. AND A. CAURCHILL (London).
Abdominal Pain. Its Causes and Clinical Significance. By A. Ernest Maynard, M.B., B.S. (Lond.). Pp. 304. Price 7s. 6d. net.
The Blood, How to Examine and Diagnose its Diseases. By Alfred C. Coles, M.D., D.Sc. Third Edition. Illustrated. Pp. 340. Price 10s. 6d. net.
The Book of Prescriptions (Beasley). Rewritten by E. W. Lucas, F.I.C., F.C.S., with an Introduction by Arthur Latham, M.A., M.D., &c. Eighth Edition. Pp. 366. Price 5s. net.
- Wm. CLOWES AND SONS, LTD. (London).
The King's Coronet. By R. Henslowe Wellington. Pp. 292. Price 10s. 6d.

CHARLES GRIFFIN AND CO., LTD. (London).
Foods and Dietsaries. A Manual of Clinical Dietsetics. By R. W. Burnet, M.D. Fourth Edition. Pp. 204. Price 4s.
H. K. LEWIS (London).
The Sanitary Inspector's Handbook. By Albert Taylor. Fourth Edition. Illustrated. Pp. 455. Price 6s.
Dental Surgery for Medical Practitioners and Students of Medicine. By A. W. Barrett, M.B.Lond., &c., &c. Fourth Edition. Illustrated. Pp. 159. Price 3s. 6d.
LONGMANS, GREEN AND CO. (London).
Recurrent Effusion into the Knee-Joint after Injury. By Sir William Bennett, K.C.V.O., F.R.C.S. Illustrated. Pp. 29. Price 3s. 6d.
In Watchings Often. Addresses to Nurses and Others. By the Rev. E. B. Holmes. With a preface by the Right. Rev. The Lord Bishop of Lincoln. Pp. 242. Price 2s. 6d.
An Atlas of Dermatology. By Morgan Dockrell, M.A., M.D. Illustrated. Price 50s. net.
The Royal University of Ireland. The Calendar for the Year 1905 Pp. 525.
MACMILLAN AND CO., LTD. (London).
Archives of the Middlesex Hospital. Vol. IV. Pp. 159.
The Historical Relations of Medicine and Surgery to the End of the 16th Century. By Clifford Allbutt, M.A., M.D., Pp. 125. Price 2s. 6d. net.
THE OBSTETRICAL SOCIETY (London).
Transactions of the Obstetrical Society of London. Vol. 46, for the year 1904. Part IV., for October, November, and December. Edited by Herbert R. Spencer, M.D., and M. Handfield-Jones, M.D. Price 70s.
A. OWEN AND CO. (Lond n).
Alcoholic Poisoning and Degeneration. By Prof. G. Bunge, M.D., Ph.D. Pp. 27. Price 6d. net.
RIVINGTONS (London).
Health at School, considered in its Mental, Moral, and Physical Aspects. By Clement Dukes, M.D., B.S. Fourth Edition. Revised, enlarged and illustrated. Pp. 606. Price 10s. 6d. net.
SPOTTISWOODE AND CO., LTD. (London).
The Medical Register, 1905. Pp. 1,764. Price 10s. 6d.
The Dentist's Register, 1905. Pp. 244. Price 3s. 4d.
ELLIOT STOCK (London).
The History of the Society of Apothecaries of London. By C. R. B. Burrett, M.A. Illustrated. Pp. 310. Price 21s. net.
WILLIAM WOOD AND CO. (New York).
The Influence of Growth on Congenital and Acquired Deformities. By A. B. Judson, A.M., M.D. Illustrated. Pp. 276.
JOHN WRIGHT AND CO. (Bristol).
The Medical Annual. A Year book of Treatment and Practitioners' Index. 1905. Twenty-third year. Pp. 843. Price 7s. 6d. net with Stereoscope at 2s. or 2s. 6d. extra.
Errors of Refraction and their Treatment. A Clinical Pocket-book for Practitioners and Students. By Charles Blair, M.D. Pp. 103. Price 2s. 6d. net.
Poisonous Plants of all Countries. By A. Bernard Smith, Pp. 88. Price 2s. 6d. net.
First Aid to the Injured and Sick. An Advance Ambulance Handbook. By L. J. Warwick, B.A., M.B., &c., and A. C. Tunstall, M.D., F.R.C.S. Third Edition, revised. Pp. 236. Price 1s. net.

Medical News.

King Edward's Hospital Fund.

AMONG the latest contributions received at the Bank of England for King Edward's Hospital Fund for London are the following annual subscriptions: Mr. Adam Mortimer Singer, £100; Mr. John G. Griffiths, £21. Donation: Mr. T. F. Blackwell, 1/52 10s., Mr. Edgar Speyer, a member of the General Council of this Fund, has, with the approval of the Prince of Wales, the President, offered a prize of £100 and a silver cup for the best essay on "Economic Management of an Efficient Voluntary Hospital." The successful competitor will receive the prize from the hands of H.R.H. the Prince of Wales. Only paid secretaries and assistant secretaries of voluntary hospitals in the United Kingdom and Ireland are eligible for competition.

The Royal Commission on the Care of the Feeble-Minded.

MR. ARTHUR DOWNES, senior medical inspector, stated that in future all children would be certified under the Lunacy Act. The Board had instituted small homes in London for mentally defective children who attended special classes in the Board Schools, an arrangement which had proved satisfactory.

London School of Tropical Medicine (University of London).

The following candidates have passed the Examination in Tropical Medicine at the above School:—Dr. H. Ludovici (Colonial Service), Dr. F. B. Thompson (Colonial Service), Miss H. B. Hanson, M.D., with distinction. Miss E. Watts, Dr. R. F. Williams

(Colonial Service), Dr. H. A. Foy, Miss M. E. Hayes, M.B., Dr. R. Van Someren.

Royal College of Surgeons in Ireland, Fellowship Examination.

THE following candidates, having passed the necessary examination, have been admitted Fellows of the College:—Mr. S. S. Pringle, M.B., B.Ch., University of Dublin, Surgeon to Mercer's Hospital and Mr. W. I. de Courcy Wheeler, M.D., B.Ch., University of Dublin, Surgeon to Mercer's Hospital.

Physicians' and Surgeons' Examinations.

At the April meetings of the Conjoint Board of the Royal Colleges of Physicians and Surgeons of Edinburgh and Faculty of Physicians and Surgeons of Glasgow held in Glasgow the following candidates passed the respective examinations:—

First Examination (5 years' course).—Robert Anderson, James Denis Collins, Robert M. Danks, Narayan K. Desai, Albert R. H. Harrison, John Alexander Irwin, Ambrose Macaulay, Narmadashanker S. Vaid, Burrington Harcourt Willoughby.

Second Examination (5 years' course).—John Austin Joseph Crowley, James M'Turk, Harold Ainscough Higginson, Harold Hilton Bradley, James Jefferies, Thomas Richard M'Kenna, George Coats, James Logan, Peter John M'Airdle, Thomas Ormiston Wilson, James Henderson Milne, Henry Gilbert Higgins, Maurice Fitzgerald Anderson, William Francis Gordon Scott, Owen Thos. Jones, John D. Jones, Walter E. Barrett.

Second Examination (4 years' course).—Jesudasani S. Lamech, John Hamilton Fullarton.

Third Examination.—John Robert Dunn Holtby, (with distinction); George Hart, William Frederick F. Durr, Ronald Wingrave Duncan, Charles Harold Bannerman, Frederic James Breakell, Norman Bennington Watch, Joseph Hume Patterson, William Wilton Johns, James Alfred Ashurst (with distinction); Andrew Ford Garrand, Gavin Watson Hill, Arnold M'Millan, John Theodore Anderson, William Turner Carter.

Final Examination and admitted Licentiate of the three Co-operating Authorities:—Percival Henderson, Sites Chunder Chuckerbutty, Ernest Gaunt, Paul Alexander M'Donald, Charles Harold Bannerman, Alexander Jack, William Watkin Neilson Knox, William Millar Ramsay, Thomas Percy Cox, William Hawkey Woodger, Jnanendra Nath Datta, Sydney Malcolm Dickson, John Wylie, Rudolf Baranov, One candidate also passed in medicine, five in surgery, seven in midwifery, and eight in medical jurisprudence.

THE Mercers' Company have given a donation of £52 10s. towards the funds of the British Orphan Asylum, Slough, for which charity a special appeal for help is now being made.

£4,000 has been granted by the French Government in aid of the International Congress on Tuberculosis, which is to be held in Paris in October.

THE Vaccination Prosecutions Bill, which provides that no prosecution under the Vaccination Acts shall be commenced without the authority of the guardians, was presented and read a first time last week.

THE second annual Welsh medical dinner will be held at the Great Central Hotel, Marylebone, W., on Friday, May 19th, when the chair will be taken by Sir Richard Douglas Powell. Further information can be obtained from Dr. Ernest Jones, 13, Harley Street, W., or Mr. J. Howell Evans, M.Ch., F.R.C.S., 31, New Cavendish Street, W.

THE annual dinner of the Pharmaceutical Society of Great Britain will be held in the Whitehall Rooms, Hotel Metropole, London, on Tuesday, May 16th, at 6.45 for 7 o'clock p.m. precisely.

FRIEDENHEIM HOSPITAL, Swiss Cottage, N.W., has received from the trustees of the Zunn Fund a donation of £3,000 for the purpose of maintaining a cancer ward of four beds to be named the "Annie Zunn" Ward.

THE annual Festival Ball in aid of the Italian Hospital will be held at the Royal Institute of Painters in Water Colours, on May 15th.

Notices to Correspondents, Short Letters, &c.

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

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 re-forwarding 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.

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.

PHYSICS.—We intend drawing attention to the matter in an early issue.

L.R.C.P.—The Dean of the College will give the information required.

INVALID.—You will find all you want about the climate of Madeira in a reprint of articles on that subject by Sir Chas. A. Gordon, K.C.B., M.D., published by Messrs. Bailliere, Tindall and Cox.

HYGIENE.—Both in the lay and the medical press the question of antiseptics in barbers' shops has been widely discussed. The Incorporated Guild of Hairdressers, Wigmakers and Barbers have themselves asked the various City Corporations to make inspection, and the City of London has agreed to do so.

ALZHEIMER.—With regard to adolescent insanity and secondary dementia Dr. Sérioux, of Paris, asserts that the curability of the hebephrenic and katatonic forms of adolescent insanity to be only 1 in 10.

DR. F. (Leicester).—Your query re cancer in the lower vertebrae has been put before. The Imperial Cancer Research Fund only succeeded in getting together a small number of cases from all over the world. It has, however, been produced experimentally in numerous instances.

MOTORIST.—The Report of the Departmental Committee on Industrial Alcohol was issued as a Parliamentary paper early in the month. You will find a full report in the *Pharmaceutical Journal* for April 22nd, including the clause re Spirit for Motor Cars.

DR. F. (Saltscoats).—Davos ought to suit you. It is generally spoken of as a winter resort, but is largely frequented all the year round. Although it is under snow for five months it is not, as generally stated, above the snow line.

OBSTETRICIAN.—Stypticin for uterine hæmorrhage has been largely used, but a definite opinion concerning its value is not yet known. The true name of the drug is cotarnin hydro-chlorate, a base obtained from narcotin by oxidation.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, APRIL 26th.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus, E.C.),—8.30 p.m. Discussion upon Influenza (second evening). Dr. W. Bullock (Bacteriology), Dr. T. G. Lyon (Clinico-Pathology), the President (Dr. F. J. Smith) (Treatment). The General Discussion will be open to all members of the medical profession.

FRIDAY, APRIL 28th.

CLINICAL SOCIETY OF LONDON (28 Hanover Square, W.),—8 p.m. Exhibition of Clinical Cases followed by discussion. Patients will be in attendance from 8 to 9 p.m.

Vacancies.

Kent and Canterbury Hospital, Canterbury.—A House Physician. Salary £90 a year, with board and lodging. Applications to the Secretary.

Wandsworth Union.—Senior Assistant Medical Officer. Salary £145 per annum, with apartments, board, and washing. Applications to the Medical Superintendent of the Infirmary.

Newcastle-upon-Tyne Dispensary.—Resident Medical Officer. Salary £250, with furnished residence. Applications to the Honorary Secretary, Joseph Carr, 41 Mosley Street, Newcastle-upon-Tyne.

Liverpool Infirmary for Children.—House Surgeon. Salary £100 per annum, with board and lodging. Applications to Arnold J. Cleaver, Government Buildings, Liverpool.

Gartloch Asylum (near Glasgow).—Medical Officer (Junior). Salary £125 per annum with board, lodging, and laundry. Applications to the Medical Superintendent.

Manchester Royal Infirmary.—Medical Practitioner. Salary £150 per annum. Applications to W. L. Saunders, General Superintendent and Secretary, Manchester Royal Infirmary.

University of London.—William Lindley Studentship. Salary £100 per annum. Applications to A. W. Becker, Principal, University of London, South Kensington, S.W.

Warwick County Asylum.—Assistant Medical Officer. Salary £100 per annum, with full board, &c. Applications to Medical Superintendent, Hatton Asylum, Warwick.

House Surgeon.—Salary £100, with board. Applications to Mr. P. W. Walker, 18 Waterloo Street, Birmingham.

Nottingham General Hospital.—Assistant House Physician. Salary £100, with board, lodging, and washing in the hospital. Applications to the Secretary.

Bristol General Hospital.—Senior House Surgeon. Salary £150 per annum. Board, residence, &c. Applications to the Secretary.

National Maternity Hospital, Dublin.—Intern Medical Assistant Master. Salary £50 per annum. Applications to Secretary.—(See Advt.).

Appointments.

ASHTON, GEORGE, M.D. Manch., M.R.C.S. Eng., L.R.C.P. Lond., has been re-appointed Assistant Surgical Officer to the Manchester Royal Infirmary.

BOWEN-JONES, E. M., L.R.C.P. Lond., M.R.C.S. Certifying Surgeon under the Factory and Workshop Act for the Carmarthen District of the county of Carmarthen.

CLUTTERBUCK, L. A., M.B., B.S., Clinical Assistant to the Chelsea Hospital for Women.

CURL, SYDNEY W., M.A., M.D. Cantab., M.R.C.P. Lond., Honorary Physician to the Essex and Colchester Hospital.

ELDER, DOUGLAS, M.B., C.M. Liverpool, Assistant Medical Officer to the Croxley Sanatorium, Delamere Forest, Cheshire.

EVANS, JOHN HOWELL, M.Ch., F.R.C.S., Assistant Surgeon to the Cancer Hospital, Fulham Road, S.W.

FERGUSON, J. P., L.R.C.P. & S. Edin., L.F.P.S. Glas., Certifying Surgeon under the Factory and Workshop Act for the Merton District of the county of Nottingham.

HUTLET, A., M.B., B.S. Edin., Senior House Surgeon to the District Hospital, West Bromwich.

JACKSON, A. I., L.R.C.P. & S. Edin. Second Assistant Medical Officer to St. Marylebone Infirmary.

KETNER, C. R., F.R.C.S. Eng., L.R.C.P. Lond., Assistant Surgeon to the Cancer Hospital, Fulham Road, S.W.

MCLARTY, A. A. M.D. U.S.A., Clinical Assistant to the Chelsea Hospital for Women.

MITCHELL, ALEXANDER, M.B., M.S. Edin., Assistant House Surgeon at the District Hospital, West Bromwich.

Births.

TUTTON.—On April 20th, at 17 Bardwell Road, Oxford, the wife of Dr. A. E. H. Tutton, F.R.S., of a daughter.

WILLIAMS.—On April 17th, at the Moat, Harrow-on-the-Hill, the wife of A. H. Williams, M.D., of a son.

Marriages.

BURNAND-BRASS.—On March 29th, at St. Cyprian Church, Durban, Walter Eardley Burnand, M.R.C.S., L.R.C.P., third son of L. W. Burnand, M.A., Worthing, to Emma Jane Brass, youngest daughter of the late A. Brass, Esq., Jamaica.

Deaths.

CHAMBERS.—On April 23rd, at 27 Cheriton Gardens, Folkestone, Alice, daughter of William F. Chambers, M.R.C.S., and Edith Chambers, aged 24 years.

READ.—On April 20th at the residence of his daughter, Mrs. J. Sharratt Horne, "Stradbroke," Reading, Charles George Read, M.R.C.S., late of Stradbroke, Suffolk, in his 84th year.

SIBBALD.—On April 25th, at 18 Great King Street, Edinburgh, Sir John Sibbald, M.D., F.R.C.P.E., late Commissioner in Lunacy for Scotland, aged 72.

TROLLOPE.—On April 21st, at Derwent Lodge, Mase Hill, St. Leonards-on-Sea, Thomas Trollope, M.D., Cantab., M.R.C.P., &c., in his 75th year.

WARNER.—On April 17th, Edward Henry Warner, M.D., of 28 Lawrence Hill, Bristol, aged 48.

LADY TRAINED NURSE would be glad to hear of child requiring country home. Cottage in pretty country village. Bracing air. Individual attention. Highest references given in exchange.—MISS CALVERT, Whipnade Common, near Dunstable, Beds.

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Original Communications.

MÉNIÈRE'S COMPLEX OF SYMPTOMS:

WITH A CRITICISM ON QUINCKE'S LUMBAR PUNCTURE TREATMENT AND AN ACCOUNT OF THE FIRST RECORDED CASE TREATED SUCCESSFULLY BY HYPNOTIC SUGGESTION.

By T. WILSON PARRY, M.A., M.D.CANTAB.

PART I.

MUCH has been written on the subject of aural vertigo and its relation to certain other associated symptoms. Besides numerous general text-books that devote each their chapter to an inquiry into the consciousness of disordered equilibration, a number of special text-books, going further into detail and weighing the opinions and theories of students who are endeavouring to solve some of the difficult and delicate problems that present themselves in connection with this subject, are also before the medical profession. In addition to this I have before me a list of over 260 papers written in English, German, French, and Italian, contributing facts of both analytical and synthetical importance bearing direct relation to that complex of symptoms to which Prosper Ménière first called attention and to which, in consequence, his name has been attached in the various forms of Ménière's "Disease," Ménière's "Syndrome," or Ménière's "Complex of Symptoms."

The first question we naturally ask ourselves is—Are these terms used by the profession as synonyms for one and the same clinical and pathological process, or has there been, in the lapse of time since it was first so brilliantly described by its French discoverer, a re-adjustment of terms, to keep pace with our growing knowledge of the subject?

On inquiry into the literature of the subject there is not the slightest doubt that much confusion has arisen from the indiscriminate applications of the term "Ménière's Disease," by authors to various conditions of both the internal and middle ears. The very fact that the term "True Ménière's Disease" exists is a confirmation of this. London otologists, at the present time, distinguish between two conditions. A case is either one of "(true) Ménière's Disease," or it is one of "Ménière's Syndrome," "Ménière's Complex of Symptoms," or, simply, "Ménière's Symptoms." How does this agree with the consensus of opinion to be found in the literature of the subject to which I have already alluded? The answer is—partly, but not altogether, as follows—A large number of writers disagree with and criticise the "Ménière's Disease," and many others who do not feel obliged to preface their remarks by an explanation of the term, a necessity which, it must be admitted, implies a weakness and lack of precision in our nomenclature.

I shall try to clarify the problem by defining the con-

ditions that give rise to these similar sets of symptoms. There are three pathological conditions which have to be considered in connection with this subject, and may be classified as follows:—

CLASS I. *Primary Labyrinthine Lesion (or Irritation).*

—(A) An acute exudation or sudden hæmorrhage into the labyrinth. This is the "(true) Ménière's Disease" of all authors. (B) Chronic labyrinthine lesion, not due to the above causes. The causes of the cases of this class are usually obscure. This is the "Ménière's Disease" of some authors and the "Ménière's Symptoms" of others.

CLASS II. *Secondary Labyrinthine source of Irritation.*

—In this class of cases labyrinthine disturbance is produced by extra-labyrinthine causes. These are chiefly tympanic in origin. This is the "Ménière's Symptoms" of all writers.

Cases of true Ménière's Disease are of extreme rarity. Indeed, so great an authority as Frankl-Hochwart (1) who has searched the whole field of otological literature, has only been able to collect some twenty-seven assured cases. Gottstein (2) in a period of thirteen years, only came across three. Cases, on the other hand, that I have placed in my Class I. B division are by no means uncommon. It is in dealing with this class of cases that confusion arises in the minds of clinical observers. In my Class II. are to be found all those cases in which irritation of the labyrinthine nerves is set up, indirectly, by some disease or disorder of extra-labyrinthine origin. These cases are too numerous to mention, but must not be omitted from a classification of this kind, as the Ménière's "Complex of Symptoms" may be imitated so closely that the cases are often diagnosed as Ménière's Disease. I say "closely imitated," because there is one point of difference that may be distinguished with ease; this is that the deafness in cases belonging to Class I. is of nerve origin, while that, if deafness there be, in those of Class II., is due to defect or disturbance in the sound-conducting and not in what is, perhaps wrongly, called the "sound-perceiving" apparatus.

I shall now describe the symptoms of "(true) Ménière's Disease" (Class I., Division A), contrasting them with those of Ménière's Disease (so-called); (Class I. Division B), and with cases exhibiting Ménière's Symptoms, but not of primary labyrinthine origin (Class II.). There are three symptoms of primary importance that may present themselves in all three conditions—viz., (1) deafness, (2) tinnitus, and (3) vertigo; and others of perhaps less importance to the diagnostician, but of no small consequence to the patient; these are nausea, vomiting, faintness (even to syncope) and profuse perspirations. In true Ménière's Disease deafness occurs with dramatic suddenness. Previously to a definite day and hour—nay, even to a very moment, there may have been no impairment whatever of either auditory organ. From this moment vertigo and tinnitus simultaneously make their appearance. Vertigo usually occurs in attacks varying in degree from the slightest swimming in the head to the severest paroxysm, when the patient feels either himself or his surroundings whirled rapidly round in one

particular direction. His equilibrium being lost, he either falls to the ground or only saves himself from so doing by clutching at objects within his reach, while at the same time he retches or vomits, even to blood. A faintness then steals over him and he breaks out into a profuse, clammy perspiration. The tinnitus remains either as a perpetual singing, humming, or whistling in the ear, or as sudden outbursts of shrill sounds, the noise of falling cascades or reports as if firearms were being discharged.

In Ménière's Disease (Class I., Division B), and in those cases that exhibit Ménière's Symptoms (Class II.) the symptoms usually begin very gradually. To begin with there is sometimes only occasional singing in the ear and perhaps slight deafness; then the singing becomes continuous, and the deafness gradually but surely increases, till later, when the deafness and tinnitus become prominent symptoms, vertigo steps in with its alarming paroxysmal intensity, and not rarely combined, with nausea, retching and vomiting, completes the clinical picture of Ménière's Symptoms.

When these "Symptoms" have once set in definitely, it is practically impossible to say, without going carefully into the history of its origin, whether the case in point is one of true Ménière's Disease (Class I., Division A), or one of its counterfeits (Class I., Division B, or Class II.), for the affection is as vexatious and persistent as true Ménière's Disease itself. I have notes in my Case-book of many cases of Class I., Division B, and it is remarkable that with all the irksome anxiety to which some of its victims have to submit, their friends are sometimes incredulous enough to regard them as troublesome neurotics.

What is the pathological interpretation of this group of symptoms? Let us first take those of true Ménière's Disease (Class I., Division A).

The first case that Ménière was able to study, both clinically and pathologically, is too well known to be described again. The acute "Ménière's Symptoms," recorded clinically during life, in that case were associated with a reddish, plastic exudate, found after death, in the semi-circular canals, and partly in the vestibule. It was of the nature either of a rapid exudation of blood-stained serum or of a hæmorrhage. There is no doubt that to coincide with the sudden onset of the clinical symptoms, the pathological change must be a very rapid one; and this is consistent with a rapid exudation into the membranous labyrinth causing a sudden increase of intra-labyrinthine tension. Since Ménière's time a considerable number of post-mortem examinations have been made of fatal cases of leucocythæmia (3), in which pronounced Ménière's Symptoms were present during life; in these, examination after death showed hæmorrhages into the semi-circular canals, vestibule and cochlea. If the one essential characteristic of true Ménière's Disease not supervening on a previous disease be labyrinthine apoplexy, then these are all undoubted cases of true Ménière's Disease; for the microscope clearly reveals the peri-lymphatic space between the membranous and osseous semi-circular canals completely filled up with an effusion of blood, some of which has been organised into newly-formed bone. The scala tympani of the cochlea is also seen to be filled with organised blood-clot. The symptom of sudden vertigo is thus easily explained by a sudden escape of blood or serum into the labyrinth, which increases intra-labyrinthine tension by the extra amount of fluid pressed into the space that only holds a constant quantity of peri-lymph under normal circumstances. Excessive mechanical pressure thus induced, acting on the vestibular nerve-endings, produces an irritation which provokes the urgent consciousness of disordered equilibration. The symptoms of tinnitus (positive) and deafness (negative) are auditory phenomena, and are due to irritation and loss of function, respectively, of the cochlear branch of the auditory nerve. [This inference is borne out by those analogous cases of leucocythæmia in which hæmorrhage, or its organised results, are discoverable in the cochlea after death.] This "auditory" nerve travels to the

nucleus accessorius, thence as auditory fibres, along the stria acoustica, and, ascending in the lemniscus, passes upward to the cerebrum without the intermediation of the cerebellum to which the equilibrial fibres eventually find their way. The other symptoms—viz., pallor, prostration, syncope, cold clammy sweat, nausea, and vomiting, are explained by a passing stimulation of the adjacent medullary centres (cardiac, vaso-motor and secretory), which lie in close anatomical relation with the nucleus of the eighth nerve. To explain the symptoms of faintness or syncope that may occur synchronously with vertigo, Dr. Woakes (4) has pointed out a line of direct communication between the heart and the labyrinth. While the sound-conducting apparatus is supplied by the external and internal carotids, the sound-receiving apparatus is supplied by quite a different blood supply—viz., the vertebral. On this artery a rich plexus of nerves, derived from the inferior cervical ganglion, finds its way to the labyrinth, and from this ganglion also proceeds one of the principal nerves controlling the heart's action. It is not therefore surprising that vertigo may induce faintness or syncope, or conversely that these may accompany a well-defined attack of Ménière's Symptoms.

How, secondly, do we explain pathologically the Ménière's Symptoms that occur in cases of Ménière's Disease (Class I., Division B), and those in Class II., of secondary labyrinthine irritation, that exhibit these symptoms.

It has seemed to me that these symptoms may be caused, in the first instance, not only by the mechanical causes to which I have already referred—i.e., by an increased quantity of fluid, by its presence temporarily raising intra-labyrinthine pressure and thus stimulating the peripheral expansion of the equilibrial nerve to produce the consciousness of disturbed equilibration—but that the *quality* of the lymph may bring about the same result. Is it not reasonable to think that quantities, even of an infinitesimal amount, of toxic substances present in the endo- or peri-lymph may act in a chemical manner upon the exquisitely sensitive ampullar nerve-endings of the auditory nerve? Would not this account for the action of certain drugs—quinine to wit—which, in a toxic dose, will produce the trio of Ménière's Symptoms? Hitherto no good explanation appears to have been offered of the action of these drugs which when administered in toxic doses produce vertigo. Might not such an impurity account for gouty vertigo also? The gouty diathesis implies a toxic condition of the blood from either an excess in production of the toxic results of metabolism or from defective elimination and consequent accumulation in the system. Is it not likely that toxic material of one kind or another may enter the labyrinthine endo- and peri-lymph, which lies close to the labyrinthine blood vessels, and acting on the impressionable ampullar nerves, whose end-organs it continually bathes, warn the individual by the disconcerting sensation of vertigo of the presence of a danger needing immediate attention. To me this speculation appears most probable, and although I have unfortunately not the opportunity of proving the correctness of it, it seems to me to be one well worth investigation, although on account of the small amount of endo- or peri-lymph at disposal for investigation and the probable lack of delicate enough analytical apparatus, a negative result of any such experiment could hardly be taken, at present, as disproof. To a dog a toxic dose of quinine sufficient in its case to cause definite vertigo might be given and then having been killed immediately traces of this alkaloid might be sought either in the endo-lymph or in the cerebro-spinal fluid, which is in direct communication with the peri-lymph of the labyrinth.

As regards the relation of the symptoms of Ménière's Disease to the pathological condition of cases belonging to Class II., it has seemed to me that when one considers the minuteness of the dimensions of the tympanum (some five lines from before backward, three lines in the vertical direction and between two and three in the transverse), it is not difficult to conceive that if there be a chronic foetid discharge with obstructed egress from

a partially blocked Eustachian tube and, maybe, a perforation in the tympanic membrane, perhaps small and highly placed, doses of toxic material may under certain circumstances find their way into the labyrinthine lymph by permeating the thinned or eroded labyrinthine walls, or by penetrating an affected fenestral membrane and thus causing irritation of the vestibular end-organs and giving rise to well-marked Ménière's Symptoms. Would not this explain why Ménière's Symptoms so frequently occur in cases of otitis media?

Of extra-labyrinthine causes in the production of Ménière's Symptoms, affections of the tympanum may most frequently be held to account. Otitis media is by far the commonest cause of the malady, but any disorder or disease of the middle-ear producing pressure on the foramen ovale, and thus increasing intra-labyrinthine pressure, may give rise to its well-recognized trio of symptoms. Fixation of the stapes is answerable for a large majority of such cases. In a series of cases published by Burnett (5), the well-known American otologist, excellent results appear to have occurred in the case of retracted and ankylosed ossicles by, first, removing the malleus in order to liberate an impacted stapes; secondly, by removal of both incus and stapes; thirdly, by removing the stapes only, and, fourthly, by simply breaking off and taking away the long process of the incus. Burnett came to the conclusion that it is the best treatment to employ the last method, especially as it is followed by the least inflammatory reaction. By removing the long process of the incus, a severance of the retractive power of the incus from the stapes is brought about, intra-labyrinthine pressure is reduced, and the tympanic vertigo relieved. He thought that puncture of the foot-plate of the stapes would be justifiable for relief of intra-labyrinthine pressure, but I can find no recorded case of this having been attempted. Spasmodic contraction of the tensor tympani muscle, or paralysis of the stapedius by allowing the foot-plate of the stapes to sink into the oval opening, will also produce the vertigo of Ménière's Symptoms. Politzer (6) describes a case in which a bony growth on the external labyrinthine wall, that had grown over the foramen ovale and was united to the stapes, produced symptoms of true Ménière's Disease, and I have notes of a case of cholesteatomata in the tympanum producing Ménière's Symptoms. Conditions of the external auditory meatus in which there is lodged a tightly-fitting foreign body or a plug of cerumen, together with an impermeable Eustachian tube, will produce, according to atmospheric changes, a positive or negative pressure in the tympanum, and this will give rise sometimes to well defined Ménière's Symptoms, which are, of course, readily cured by the removal of the foreign body or cerumen and the opening of the Eustachian tube by the catheter and india-rubber air-bag. Moos (7) relates a case of Ménière's Symptoms that was sent to him, when he was in charge of the ear clinic, from the medical clinic, diagnosed as a case of Ménière's Disease. All the symptoms (vertigo, deafness, tinnitus and vomiting) disappeared on removal of a plug of wadding from the right ear. Another cause of secondary labyrinthine lesion (Class II.) is cerebro-spinal meningitis. In this disease an otitis labyrinthica is set up by direct communication from the cerebro-spinal fluid to the peri-lymph of the labyrinth. Gottstein cites two cases in children which were brought to his clinic suffering with deafness, tinnitus and a staggering gait. He found there had been an outbreak of cerebro-spinal fever in the district from which they came, and although these individuals had not been under medical care, the time they were acutely ill was found to be coincident with that of the cerebro-spinal fever epidemic. Cohn of Breslau found evidences in the eyes of such a nature as to lead him to suppose, as the eyes and ears of these two patients had been affected at the same time, that they had both had cerebro-spinal meningitis.

The treatment of cases belonging to Class I. has not been at all successful up to the present. The drugs recommended, apart from the primary aperient and

stomachics, are the bromides, quinine, potassium iodide, salicylates, arsenic, ammonium chloride and gelsemium. If the symptoms are of syphilitic origin calomel and potassium iodide is the treatment *par excellence*. In other cases the bromides and quinine are undoubtedly by far the best drugs. Charcot was the first strongly to advocate quinine, and in a paper by Dr. E. Ménière (8) ["Causes et traitement du vertige de Ménière"] this author, who has taken special interest in the disease that was first described by his father, urges that, without neglecting other therapeutical means, quinine ought to be always prescribed as it has often been successful. Dr. J. M. Bradley (9) comments on the fact that although many recommend the use of quinine, no directions are given for its administration. He lays down rules for the treatment. He begins by finding out for the particular patient the minimum toxic dose of the drug, and taking this as a starting point he increases the drug gradually until the patient begins to complain of an increase in the tinnitus. This limit is taken as the patient's maximum dose, and is the dose, he affirms, which will control the paroxysms of vertigo. As quinine is quickly eliminated from the body, being practically gone in twenty-four hours, he does not propose to keep the patient on the maximum dose, but gives it in such a way that the good effects of the maximum dose, without cinchonism, will be kept up without having to reduce it suddenly to the minimum dose on account of intolerance from toxic discomfort. In a case of true Ménière's Disease (10), published by myself at the beginning of last year, I gave excellent temporary relief of symptoms by the application of a seton in the nape of the neck; and Mr. Colin Campbell (11) published a case of Ménière's Symptoms in which similar treatment produced the happiest possible results. In my own case unfortunately I left the neighbourhood before the treatment was established on a sound footing, namely, on April 25th, 1902, when the patient had been under my watchful care for over two years. On the following September 17th, my successor wrote me: "— had no fit after you saw him, resumed light work at the end of May and went back to his own work in the second week in June. On June 23rd I removed the seton. On July 26th he had a severe attack of vertigo and three days later he had two severe attacks, with one of which he vomited. I introduced a fresh seton on July 30th, and since then he has had no severe fit, and latterly none at all; he has now resumed light work." To sum up—I introduced the seton on April 6th, and from April 10th to July 26th (a period of 3½ months) there was no fit whatsoever. After the seton was removed, a thing I should never have done myself, had I been still treating the case (as six months is the minimum time for insertion), the attacks remained in abeyance for a month; and when a fresh seton was inserted on July 30th the attacks vanished again and did not return for another three months at least. Unfortunately, no accurate account was kept after my note of September 17th, but on the following March 10th I had word to say that the patient had been free from attacks "for a time," and then had gone to work with the seton *in situ* and had had a recurrence of the vertigo subsequently, when the seton was withdrawn. At this period, again, had the case been under my care, I should have immediately recalled him from his work and inserted, if necessary, a second seton. The reasons I have such full faith in the seton, after drugs have been found to be of no avail, are the following:—

1. When a seton is placed at a spot not far removed from the position of any lesion, the determination of blood to this new surgical site will tend to diminish the quantity of blood at the affected part.
2. I believe that it acts reflexly on the vaso-motor system by means of the sympathetic, so as to cause constriction of the vessels in the vicinity of the lesion.
3. The presence of a seton causes a definite psychical effect by determining a constant and continuous "reminder" of its presence. Its presence acting on the central nervous system produces a transference of

the consciousness of a trouble of one kind, in one part to that of a different nature in another.

From personal observation I am quite assured of the fact that anyone suffering from "Ménière's Symptoms," unless possessed with an inordinate strength of will and character, will, after a time, become apprehensive of a dreaded attack taking place—nay, some, indeed, actually live in terror of their approach—and this very apprehension may produce a vertigo, which, though not due to the original cause, occurs from vaso-motor disturbances and simulates the primary attack itself. Just as some suffer from morbid blushings of the face due to disturbance of the sympathetic system from emotional causes, so hyperæmia of the labyrinthine vessels may be produced by fear and anticipation of a recurring paroxysm of vertigo. If such a treatment can be of practical use in true Ménière's Disease, it is a treatment I should unhesitatingly recommend for any case of Ménière's Symptoms that does not quickly and certainly respond to drug treatment.

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- (8) Thirteenth Congrès International de Médecine, Paris, 1900, par Dr. E. Ménière.
- (9) *The Therapeutic Gazette*, Detroit, 1903, Third Series, xix., 660, by J. M. Bradley, M.D.
- (10) *Lancet*, March 5, 1904.
- (11) *Brit. Med. Journ.*, March 29th, 1902, p. 806.

(To be Continued)

MUNICIPAL MILK DEPOTS AND MILK STERILISATION, (a)

By G. F. McCLEARY, M.D. CANTAB., D.P.H.,
Medical Officer of Health of the Metropolitan Borough of Battersea.

THE object of the municipal infants' milk depot is to reduce the heavy infantile mortality dependent upon improper infant feeding. We know, of course, that mother's milk is immeasurably the best food for babies, and that a baby should receive

nothing but mother's milk for at least the first nine months of life, but we know also that in many cases mother's milk is not available, and that an increasing number of children must either be fed artificially or not at all. Cow's milk is the least objectionable substitute for mother's milk, but many children in our poorer districts hardly ever taste cow's milk; they are fed on condensed milk and cheap proprietary foods. Moreover, cow's milk as usually supplied in this country may be, and often is, a source of grave danger. It is grossly contaminated, the contamination taking place on the farm, in transit, in the milkshop, on the milk-round, and last, but certainly not least, in the home of the consumer. Dr. Newsholme and Dr. Meredith Richards have brought forward strong evidence for the opinion that the home-contamination of milk and other foods is a most important factor in the causation of summer diarrhoea; and the prevention of home-contamination must be an essential part of any effective scheme for the reduction of the infantile mortality dependent upon improper infant feeding. By supplying milk in separate bottles, each bottle containing sufficient for one meal and no more, the danger of home-contamination is minimised, for the bottle is not opened (or, at all events, need not be opened) until the baby's feeding-time has arrived.

The heating process to which the milk is subjected at the depot neutralises largely, if not wholly, the initial contamination, and as the milk is supplied in separate bottles the number of meals in the twenty-four hours and the proper quantity for each meal are clearly indicated, and the danger of over-feeding is, therefore, minimised. In addition to these advantages a properly-conducted infants' milk depot is an important educational influence. It is a striking object lesson in methods of artificial infant feeding, and it performs a useful function in rousing public interest in the important problem of the prevention of infantile mortality.

The methods upon which the infants' milk depots in this country are conducted are not, in my opinion, entirely satisfactory. In the first place, we should endeavour to remove the necessity for sterilisation. We must never forget that mother's milk is the proper food for infants, and if mother's milk is not available we must find a substitute which resembles mother's milk as closely as possible. Now, mother's milk is not a cooked food, and our aim should be to supply cow's milk in an uncooked state. This, of course, involves the ownership of the cows. No medical officer of health in his right mind would recommend a sanitary authority to supply raw cow's milk unless the whole of the processes involved in the production of that milk were placed under the effective supervision and control of the responsible officers of the sanitary authority. Such effective supervision and control can only be secured by the direct ownership of the means of production. If the sanitary authority controlled the whole of the processes of production "from the cow to the consumer" it would be possible to fulfil the following conditions, which should, in my opinion, be fulfilled in all municipal milk depots:—

1. The municipal dairy farm should be in the country, but not too far from the town, and the municipal cows should be healthy and they should live in the open air as much as possible. The sanitary

(a) Read at Sessional Meeting of the Royal Sanitary Institute, March 25th, 1905.

condition of the farm should, of course, fulfil the strictest requirements.

2. The cows should be milked in the open air, and the whole process of milking should be performed with the strictest aseptic precautions, and should be supervised by an officer trained to appreciate the importance of asepsis in surgery.

3. Immediately after milking, the milk should be cooled down rapidly to a temperature not higher than 40° F.; it should be modified if necessary, and then promptly bottled.

4. The bottles should be packed in ice, placed in a specially constructed motor wagon, and conveyed to the distributing centres in the town.

These are the methods upon which a municipal milk depot should be conducted. If they seem Utopian, all I can say is that they are in operation to-day in the City of Rochester, in the State of New York. In 1897 the municipality of Rochester began a supply of milk for infants on methods similar to those at present adopted in our own depots. At first the milk was sterilised, then pasteurised, but in 1899 the following methods were adopted. I quote from an article by Dr. George W. Goler, the Medical Officer of Health of Rochester:—

"A central station at which the milk is prepared is organised each season on a farm outside the city, where a trained nurse and assistants have full control of the cows, utensils, bottles, &c., and where all of the milk work is carried on in a portable milk laboratory. Everything coming in contact with the milk is thoroughly sterilised in steam sterilisers. The milk itself is not subjected to any pasteurising or sterilising process. Sterilising and pasteurising are only an open invitation to the milkman to be careless in the production and handling of milk.

"At the milk station on the farm the milk is taken from clean, well-fed, tested cattle into sterile cans, which are carried to the barn in sterile cheese-cloth bags. Just before milking the cows' udders are washed. A sterilised cheesecloth fly cover is placed over the cow, the first portion of the milk being rejected. So soon as the cans are filled they are immediately covered by a layer of cheesecloth held in position by a rubber band. The cans of milk thus covered are immediately taken from the barn into the laboratory, about 200 yards away, where the milk is properly diluted, sweetened, and turned off into sterile nursing bottles of various sizes of the Siebert type. The bottles are corked with sterile rubber corks, placed in racks, covered with cracked ice, and immediately transferred to the city for use. Of the cleanliness of milk prepared in this way, forty-three daily samples were found to average not more than 14,000 bacteria per cubic centimetre, while the city milk for the same period approximated 235,000 bacteria per cubic centimetre."

If this can be done by our American cousins I do not see why we Britishers should allow ourselves to be left behind. If these methods were adopted, not only would our municipal milk supplies be greatly improved, but a practical object lesson in clean milk production could be given. We could give the dairyman what we have already given the builder, namely, a working model for him to copy. At the municipal dairy farm the dairyman would be made welcome to study aseptic methods of milk production, and such an object lesson could not fail to effect a

considerable reform in the present deplorable methods on which milk is produced in this country.

Another defect of the British milk depots is that practically no provision is made for the effective individual medical supervision of the children. In the French institution—the Goutte de Lait—which may be regarded as the precursor, and to some extent the prototype, of our milk depots, the medical supervision of the children is the most important feature of the work.

What are the causes of the inability of mothers to suckle their babies? Whatever may be the case among the well-to-do classes, there can be no doubt that among the poor one of the most important causes is the mal-nutrition of the mother. Every doctor who has practised among the poor knows that bread and tea is the diet upon which many a poor mother has to subsist, and it need not surprise us to find that on an inadequate diet of bread and tea "the milk goes." The feeding of the mother during the periods of pregnancy and suckling is an important factor in the prevention of infantile mortality. The best way to humanise cow's milk is, as Dr. Sykes has pointed out, to pass the milk through the human mother. We could increase enormously the usefulness of our municipal milk depots by supplying, at a reduced price, pure milk to mothers who could bring forward satisfactory evidence that they were suckling their babies, and who would undertake to bring their babies to the depot periodically to be weighed and examined.

In addition to nursing mothers and to young infants for whom breast-feeding is impracticable, there is a third class of milk-consumers who stand much in need of pure milk. These are the older children who have passed the age of breast-feeding. Infants between nine and twelve months need not be wholly breast-fed, and children over twelve months need not be breast-fed at all; but for several years after the completion of the first year cow's milk is a most important food. For these older children, however, it is not necessary to adopt the costly method of supplying each meal in a separate bottle—it would suffice to supply the milk in pint bottles.

The conclusions of this paper may be stated as follows:—

1. Municipal milk should not be sterilised milk, but clean milk produced under the strictest possible aseptic precautions. The production of such milk involves the ownership of the cows.
2. Municipal milk should be supplied primarily to three classes of milk consumers—(a) Nursing mothers. (b) Children over nine months old. Such children would not, in the natural course of events, be breast-fed; at all events not wholly breast-fed. (c) Infants under nine months for whom breast-feeding is impracticable.
3. It should be the object of the municipality to increase class (a) so as to diminish class (c).

Paris Clinical Lectures.

GONORRHEAL POLY-NEURITIS

FOLLOWED BY DEATH.

By DR. MENETRIER,

Physician to the Tenon Hospital, Paris.

[SPECIALLY TRANSLATED FOR THIS JOURNAL.]

A PATIENT was recently admitted who presented

symptoms of paralysis of the type of generalised polyneuritis, consequent upon an attack of gonorrhœa still running an active course, and he succumbed to an intercurrent attack of bronchopneumonia. The anatomical and histological examination of the central nervous system, which was carefully carried out in this case, possesses particular interest because, so far as I am aware, the disease has never hitherto been studied except from a clinical point of view. Briefly related, the main facts are as follow:—

Admitted on October 27th, 1904, a man, æt. 46, complained of pain and inability to move his four limbs, obliging him to remain in bed. The symptoms supervened a month after the onset of an attack of gonorrhœa in April, 1904, and was still in progress. He had had several previous attacks of gonorrhœa, one of which was complicated by orchitis and all had been very severe, the discharge lasting several months on each occasion. As a matter of fact, it is difficult to ascertain for certain whether these several attacks were recrudescences of the original one or fresh outbreaks. In any event, this last attack made its appearance after ten days' incubation, and a month later the patient began to experience weakness in his legs, specially pronounced at the end of his day's work. By the end of September the weakness had increased so much that he was obliged to relinquish work. At the same time he had a good deal of pain in the lower limbs, sharp enough to prevent sleep and the pain subsequently extended to the upper limbs, which in their turn became paretic, though less so than the legs.

On admission, six months after the onset, there was still a copious purulent urethral discharge containing many gonococci, a large proportion of which—and this point deserves attention—were extra-cellular, i.e., free in the pus. The paralysis of the lower limbs was virtually complete. Not only was he unable to stand, but he could not even raise his legs from the bed. There was marked muscular atrophy affecting more particularly the adductors, and, in a less degree, the calf muscles and quadriceps extensors on both sides. Cutaneous sensibility was blunted, simple contact being scarcely felt, but deep pressure excited pain; in fact, the muscles were distinctly hyperæsthetic. Pressure on the nerve trunks was also very painful and stretching of the sciatic provoked pain. Apart from this, he suffered from spontaneous lancinating pain accompanied by "pins and needles," or cramp. No fibrillary contraction. Total abolition of the knee-jerks. The paralytic symptoms were less pronounced in the upper extremities, but there was nevertheless well-marked atrophy of the muscles of the arm and forearm, not specially bearing on any particular nerve distribution. There was no deformity and no "claw" position of the hand. Voluntary movement was not altogether in abeyance, but the movements were weak and there was muscular inco-ordination. The sensory disturbances were less marked than in the lower extremities. Cutaneous sensibility was not interfered with, and pressure on the muscles was less painful. The muscles of the trunk were not markedly atrophied, although the patient had much difficulty in raising himself into the sitting posture. The sphincters were not involved, and the joints were unaffected. No ocular troubles.

The reaction of the muscles to the Faradic current was negative in the lower limbs, but was

present in the arms, though a strong current was necessary to elicit it. In the forearm the flexors responded more readily than the extensors, but the common extensor failed to react at all.

The patient's condition became daily worse, the paralysis extended and soon involved the muscles of the neck and trunk. A bedsore formed, the temperature rose, the tongue became dry, and breathing laboured. Subcrepitant râles were heard at the right base, and he died on November 13th.

At the *post-mortem* examination, the *pia mater* was notably congested and the white matter injected. No trace of meningitis or meningeal exudation and the cerebro-spinal liquid appeared to be normal in quantity and quality. The spinal *pia mater* was also highly vascular, but not the medullary tissue either on the surface or on section. The large nerve trunks appeared to be intact, and the affected muscles, though diminished in size, presented nothing abnormal.

The pulmonary tissue at both bases was dense and sank in water, pus could be squeezed out of the divided bronchioles. Nothing to note in respect of the heart or liver. The kidneys were intensely congested, soft and swollen. The pelvis, however, did not contain any pus. In the bladder the urine was mixed with pus and the mucosa was deeply congested. Pus was also found in the urethra.

Histological examination of the nervous system gave the following results:—The spinal cord, medulla oblongata and brain were fixed in part in Müller's fluid, imbedded in collodion and stained by Weigert's method; in part, also, in aceticified sublimate, imbedded in paraffin and stained with polychrom blue or eosine-hæmatoxyline. The nerves were treated with osmic acid and teased out, the large trunks being fixed with acetic sublimate and cut into sections.

No lesion was discovered in the cortex cerebri or medulla. In the spinal cord the white columns were intact as well as the root zones, connective tissue and vessels; in fact, the changes bore only on the cells of the anterior cornua and then only on some of them. The changes were most obvious in sections from the cervical region and lumbar enlargement, being scarcely appreciable in the dorsal region. In the various sections sometimes only one or two changed cells were to be seen, while in others they were more numerous, amounting in some to a third of their number. Chromatolytic lesions predominated, especially central chromatolysis with granular disintegration and decolouration of the chromatophiles round the nucleus which persisted with a well-stained nucleolus. The cells were often swollen and globular, and the nucleus was displaced towards the periphery. Less frequently we saw cells presenting, in addition, large rounded vacuoles. The lesions in the nerves were particularly well-marked at the peripheral extremities. In the radial nerve, for instance, not a normal fibre remained. Throughout, the myeline was more or less completely disintegrated, being gathered up into beads or droplets or large masses separated by intervals, the sheath being distended here and there so as to look like a rosary. The axis cylinders, moreover, were profoundly modified, being irregularly swollen or fragmented, the axis in many instances having altogether disappeared. The lesions were degenerative without any reactional tendency.

Speaking generally, there was no trace of cellular proliferation or vegetation of the protoplasm, nor did there appear to be any invasion of leucocytes. The connective tissue and blood vessels were normal. A branch of the crural nerve presented similar lesions, which were, however, less marked in the large nerve trunks. In the brachial plexus, teased out after being fixed by osmic acid, most of the fibres were healthy, the axis cylinders and the sheath of Schwann being intact. Here and there, however, a few fibres were met with in which the myeline was broken up into droplets or beads.

The sciatic nerve presented few changes, but under a high power there appeared to be an unduly large proportion of thin fibres deprived of the sheath of Schwann, the axis cylinders nevertheless having escaped injury. The anterior and posterior roots displayed a few fibres with fragmented myeline. We found then a marked contrast between the alterations in the peripheral branches and those met with high up; in fact, the alterations diminished in proportion as we approached the centre.

Examination of the extensor communis digitorum showed the fibres to be of normal size, striation being preserved, but there was an undue abundance of nodules which, on transverse section, formed a sort of crown around each fibre. This was the only abnormality observed.

Examination of the lung tissue failed to reveal any organism at all resembling the gonococcus, but the presence of a certain number of elliptoid diplococci led us to suppose that the bronchopneumonia might have been caused by the pneumococcus. Sections of the kidneys showed, in addition to traces of old-standing sclerosis, recent lesions of vascular congestion with leucocytic diapedesis. In conclusion we must insist upon the severity and the extensive distribution of the gonorrhœal inflammation. In addition to infection of the entire urethra the crypts and glandular culs-de-sac were found to be filled with pus globules and surrounded by accumulations of leucocytes permeating the depths of the spongy bodies of the urethra, with similar lesions in the prostatic glands. The depth of these lesions explains the failure of treatment to arrest the morbid process and the severity of the collateral disturbances.

Its *clinical interest*.—From a clinical point of view then, this case is a good example of polyneuritis, the gonorrhœal origin of which cannot be called in question; indeed, the symptoms are exactly those described by Raymond, Spillmann, Haushalter, &c., but with a severity and a generalisation of paralytic phenomena altogether exceptional, and proportional to the severity of the original infection. The gravity of the complications is to be explained by the patient's state of debility, which opened the door to the bronchopulmonary infection.

What this observation adds to the history of polyneuritis in general is the demonstration of the anatomical lesions which had hitherto escaped direct investigation. The conditions observed fully confirm the clinical data by showing the localisation of the lesions in the peripheral nerves. The nervous lesions are purely parenchymatous, with integrity of the interstitial tissue, and they affect the degenerative form, involving damage of the sheath and axis cylinder without any ten-

dency to cellular proliferation or protoplasmic vegetation.

In addition to these lesions of the peripheral nervous system we discovered certain changes in the cells of the anterior cornua, partial lesions involving only a certain proportion of the cells, and unequally distributed throughout the cord, being obviously more marked where the nerves of the limbs take origin, viz., in the cervical and lumbar enlargements.

It may be asked whether the discovery of these lesions in the cord ought not to lead us to alter the name of the disease, making it both central and peripheral. Obviously the toxic origin applies equally to the central and to the peripheral lesions, but the cellular lesions just described are, as a matter of fact, exactly those which we usually regard as secondary to changes in the nerves (Marinesco) and are met with, not only in the other varieties of polyneuritis, a statement that might give rise to discussion, but also after traumatic injury to nerves, being the secondary consequence of the latter acting on the central nervous system.

With regard to the pathogenesis of gonorrhœal polyneuritis it appears to be dependent upon a process of auto-intoxication, the proof whereof is furnished in part by the analogy of the lesions just described with those of polyneuritis determined experimentally by the injection of bacterial toxins in animals.

THE THERAPEUTICS OF ASPIRIN AND MESOTAN.(a)

By J. BURNET, M.A., M.B., M.R.C.P. EDIN.

Senior Clinical Tutor, Extramural Wards, Royal Infirmary; Registrar, Royal Hospital for Sick Children; and Physician to the Marshall Street Dispensary, Edinburgh.

ASPIRIN is the acetic ester of salicylic acid. It occurs as fine white, acicular crystals, possessing a distinctly acid odour, and an agreeable acid taste. Dilute alkaline solutions readily dissolve it, splitting it up into its component parts. It is only slightly soluble in an acid medium. It differs chiefly from other salicylic compounds in being much less irritating to the gastric mucous membrane. It tends to increase the heart's activity, and does not produce tinnitus aurium. Its presence in the urine can be detected shortly after its administration. It is best given in a glass of lemon water, and must on no account be prescribed along with alkalies, nor in the form of tablets. The average single adult dose is from 10 to 15 grains.

It is in rheumatism and rheumatic affections that aspirin is more especially to be employed. I have given it in over 200 cases. To get the best results it should be given in full doses, and its administration should not be discontinued too early. It is useful in lumbago, and in pleurodynia. In cases of chorea I have had remarkably good results from the use of aspirin. In fact, I have yet to meet with a case of chorea in which aspirin, given in suitable doses, failed to bring about alleviation of the condition. It should, however, be given in doses of from 10 to 15 grains. Children take it well, and it never produces toxic symptoms. In acute rheumatism of childhood I have likewise found

(a) Abstract of Paper read before the Therapeutical Society on March 25th, 1906.

aspirin of value. It should be given in 5 to 10 grain doses every three or four hours. It is also of service in many cases of tonsillitis of rheumatic origin occurring in children.

In rheumatic eye affections, such as iritis, it will be found invaluable. In the treatment of the hectic fever of tuberculosis small doses of aspirin possess the power of reducing the temperature. As an analgesic it can be recommended, not only in many cases of neuralgia but especially in sciatica, neuritis, and even in malignant conditions. In certain forms of influenza aspirin proves extremely useful. In cases of glycosuria, as first pointed out by Williamson, of Manchester, aspirin alone is able to reduce the amount of sugar excretion.

In fact, in my opinion, aspirin entirely replaces all other salicyl compounds, as it is a more powerful analgesic and antithermic agent than any of the others.

Mesotan is the methoxymethylester of salicylic acid. It is a pale, yellowish fluid, possessing very little odour. It is readily absorbed by the skin. Having used it in nearly 200 cases, I am able to testify to its value, more especially in cases of muscular rheumatism. It is also of value in arthritis deformans, and in sciatica, two cases of the latter being greatly relieved by its application.

A good deal has been written regarding the so-called irritative effects of mesotan upon the skin. I have never yet seen any really bad results follow its employment. Care should be taken to paint it on in cases where the skin is specially delicate, and it is well to vary the area of application from day to day, and even to intermit the painting for a few days at the end of a week. Moisture decomposes it, and therefore the skin should be thoroughly dried before applying mesotan, while the latter should always be dispensed in a perfectly dry bottle. The skin should not be covered with any impervious material afterwards. If these precautions are adopted mesotan will be found to produce only good results.

The Out-Patient Departments.

EASTERN DISPENSARY.

Two Cases of Head-Nodding in Children.

By G. NORMAN MEACHEN, M.D., M.R.C.P.,
Physician to the Dispensary.

Case I.—A male infant, *æt.* 1, was brought by its mother, a Jewess, because it had a peculiar habit of shaking its head about and "putting its eyes up the corners." She had noticed this for about a fortnight. The child was fairly well-nourished and did not present evidences of rickets. The movements of the head were very striking and arrested attention directly the child came into the room. They were rhythmical, yet not continuous, side-to-side movements alternating in an irregular fashion with those of nodding. The mother stated that they ceased entirely when the child was asleep, and they certainly stopped altogether when its attention was arrested by giving it some object to look at, but they soon recommenced when its gaze wandered away again. Nystagmus was well-marked in both eyes, especially on looking to the left, and, indeed, convergence in this direction seemed to be the favourite position. Hippus was not observed. The eyes had a peculiar, pre-occupied look, yet the mother thought that he could see well, and that he was rather forward than otherwise in intelligence. He had been breast-fed up to the age of ten months.

Case II.—Three weeks later, another male infant,

æt. 1, of Gentile parentage, was brought up because it had exhibited nodding and shaking movements for the last two months. It had had no previous illnesses, but had only recently been weaned, being now fed upon milk and water and soup. In this case also the movements were both vertical and horizontal in character, and they ceased during sleep and when the attention was strongly arrested. There was no nystagmus, nor any pupillary irregularities. The child was in moderately good condition.

This extraordinary affection, first described by Hensch and Romberg in 1851, has received many different names, such as "nodding spasm" (Stephen Mackenzie); "headshaking" (Gee); "head-jerking" (Hadden); and "gyrospasm of the head" (Frederick Petersen). The number of cases in the literature is not great, being something well under eighty. Hadden had made an analysis of twenty-one cases, and his paper still remains classical. The age at which the malady usually begins is about twelve months, though cases have been recorded at two months and three years respectively. Among etiological factors of importance, troubles of dentition were supposed to be the first by Hensch, but rickets and injury appear to have been responsible for many others. In a series reported of fifteen cases by Raudnitz, deficient light was thought to have some influence in the development of the condition, especially when the child's cot was placed so that the light invariably fell upon it at the same angle and from a considerable distance away. Males and females appear to be equally affected. Nystagmus is almost always present, and some observers consider that this is the primary phenomenon. Mr. Angus M'Gillivray, of Dundee, read a paper upon nine cases of hereditary nystagmus associated with head-movements at the annual meeting of the British Medical Association, in 1895.

The relation of head-nodding to epilepsy has been much discussed. In six out of Hadden's cases there was a family history of convulsions. Marcus Gunn has suggested a relationship to epilepsy on the ground that a temporary abeyance of consciousness was observed in two cases. Pathologically, it is supposed by Petersen that some irritation is present at the roots of the spinal accessory and upper spinal nerves, added to which is some defect in the visual association-fibres from mal-nutrition, consequent upon rickets. It is certainly commoner in crowded localities and also during the darker months of the year. The question of compression at birth has been raised as possibly having something to do with the onset of the affection, but normal labour has been the rule in practically all cases. Mentally, these children are generally bright, and even precocious, so that the disease differs from that symptom-complex comprised under *esclampsia nutans*.

The prognosis is good, no fatal cases having been recorded. Gee's first case was well at the age of twelve. The movements usually yield to a course of potassium bromide and to careful hygienic management in a few weeks.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON.

A CLINICAL EVENING WAS HELD ON APRIL 28, 1905. The President, DR. FREDERICK TAYLOR, being in the Chair.

MR. JACKSON CLARKE showed three cases of Congenital Dislocation of the Hip reduced by the Method of Lorenz, with Skiagraphs. The first patient, *æt.* 7, had a typical displacement of the right hip, which was reduced in August, 1903. She was shown to the Society on October 28th, 1904, with a skiagraph, at which time the joint was stiff and abducted, exemplifying "the pubic result" with rigidity. Now the joint moves freely and without pain. The patient walks well, and the restored joint is firm. The second, a girl, *æt.* 8, was operated upon in August, 1903, for congenital dislocation of the right hip. This patient

illustrated "the normal result"—*i.e.*, the walking and anatomical conditions, save for a slight degree of abduction which is purposely maintained, appear to be the same as those of a normal child. The third, girl, *æt.* 3½, was operated upon for congenital dislocation of the right hip in June, 1904.

Mr. T. OPENSHAW was of opinion that in one of the cases the head of the femur could be felt on the lip of the acetabulum. He referred to the frequency with which the neck of the bone was rotated in this condition, and the prognosis varied according to the degree of rotation. After Lorenz's operation the head was never restored to the actual acetabular cavity, but, in spite of that, the result was satisfactory inasmuch as the function of the joint was restored perfectly.

Mr. JACKSON CLARKE agreed that often there was no true cavity into which the head could be placed; this could be well seen by dissecting infants born with such a condition. But the actual anatomical condition was unimportant so long as perfect functioning resulted. It was important to study the cases at some long interval after the operation.

Dr. MORLEY FLETCHER and Mr. BETHAM ROBINSON, showed a case of Dilatation of the Large Intestine, beginning at the Hepatic Flexure and ending in the Rectum at the Pelvic Floor. The boy, *æt.* 12, had always had a large belly. In November, 1904, there was a marked increase in abdominal distension, accompanied by constipation and some pain in defæcation, but without vomiting, and no blood was passed. Abdominal section disclosed dilatation of the large intestine. The circumference of the upper part of the rectum measured 19½ inches. The bowel was emptied *per anum* by manipulation, many pounds of soft dark fæces being forced out. The abdomen was then closed, and the result has been very satisfactory.

Dr. J. PORTER PARKINSON queried as to whether a recurrence would not take place. He had observed the presence of some dilated veins at the upper part of the abdomen and wished to know whether any other morbid condition was present.

Mr. DOUGLAS DREW referred to a similar case on which he had operated recently. Here the small intestine was also involved and very powerful contractions were present. His view as to the causation of the condition was that the nervous mechanism of defæcation was so deranged that spasm of the sphincter persisted instead of relaxation, so interposing an obstruction to the flow of contents.

Mr. C. H. MAKINS said that the case shown was unusual in that the colon was only affected below the splenic flexure. As a rule the colon did not act, so that sigmoid colotomy was not of much use.

Mr. BERTHAM ROBINSON in reply, said that no other morbid condition was present. If recurrence took place he proposed to open the cæcum and flush the colon.

Dr. FAWCETT showed a case of Kaposi's Disease. The girl, now *æt.* 16, was first noticed to have freckles when *æt.* 2½. From 3½—10 years she had corneal ulcers. Until fourteen she was at school, and had no surface lesion. For the last two years many small sores had appeared at intervals, and had left depressed scars. In January, 1905, a granulomatous patch first appeared on the left side of the nose, and continued to increase. On admission to Guy's Hospital in March under Sir Cooper Perry the granulomatous mass measured 2 in. by 1 in., and involved the left ala of the nose and left upper lip. Since the application of the X-rays the mass had diminished by one-third, the surface was cleaner, and did not bleed so readily. There were numerous freckles on the face, chin, and neck, extending over the shoulders behind, and just below the clavicles in front. They were also seen on the fingers, forearms, arms, and shins. There were small white atrophic patches on the cheeks, also thin white scars, warts, and telangiectases. On the arms were some small white flat warts.

Dr. A. M. GOSSAGE showed a case of Stokes-Adams Disease. The patient, a woman, *æt.* 58, came to the hospital a few weeks ago complaining of faintness; she had fallen several times and twitched. There was momentary loss of consciousness. The patient had

had syphilis. On examination her heart was found to be beating regularly at forty per minute, heart and pulse corresponding. The pulse was strong and the arterial tension rather increased, with decided evidence of thickening and sclerosis of the vessel wall. The heart itself was not enlarged, and there was no marked hypertrophy to be made out. There were no murmurs heard.

Mr. DOUGLAS DREW showed a Case of Tuberculosis of the Parotid Salivary Gland. The swelling commenced in the patient, a boy, *æt.* 9, about eight months ago, simultaneously with a discharge from the left ear. His father died of consumption. The swelling had the outline of the parotid gland; it was hard except for a small fluctuating area in front and slightly tender. There was no lymphatic gland enlargement. The fluctuating area was incised and scraped, whilst at the same time a portion of the mass was cut out for microscopic examination. The wound healed well, no fistula forming. The examination showed general invasion of the gland by tuberculosis and commencing caseation.

Mr. JOHN LUNN showed a case of Thoracic Aneurysm, with a weak pulse in the right carotid and subclavian arteries, and weakness and blueness of the left hand and arm. The patient, *æt.* 35, was admitted with urethral stricture following gonorrhœa twelve years before, but without a history of syphilis. Weakness and coldness of the left arm and abdominal pain appeared five weeks ago. A loud systolic murmur is to be heard over the aortic area; the apex beat is in the sixth interspace below the nipple. There is no thrill, or visible pulsation, or tracheal tugging. The pupils are unequal, the right larger than the left.

Mr. JOHN LUNN also showed a case of Tumour of the Tongue in a Girl. The patient, a girl, *æt.* 12, first noticed a lump on the tongue six months ago. About the middle of the dorsum of the tongue on the right side are two swellings, one behind the other, over which the papillæ are markedly hypertrophied. On palpation the swellings are felt to consist of indurated tissue without nodules. The right half of the tongue is larger than the left, and the cervical glands on the right side are enlarged. There are some scars at the left angle of the mouth, and evidences of past keratitis.

Mr. W. C. SPENCER thought that the condition was one of lymphangioma and would probably go on to macroglossia. Some of these cases were sarcomatous in nature. He advised operation if further growth occurred.

Dr. T. D. SAVILL showed a case of Traumatic Stricture of the Œsophagus, possibly associated with dilatation, relieved by Electricity. The patient, a woman, *æt.* 49, in the year 1880, swallowed by mistake some vitriol. This was followed by extreme dysphagia and stricture, so that two years later a bougie could only be passed with difficulty. Subsequently she learned to pass a No. 15 bougie, and did so before each meal. Thus she was enabled to swallow, besides liquids, finely divided solids. But there was, after a time, an increasing difficulty in passing the bougie, and when first seen in June, 1903, a bougie had not been passed, and she had not swallowed solids for nine weeks. Fluids could only be swallowed slowly whilst very hot and when the patient was lying down. Electric treatment was quickly followed by improvement; in six weeks she could swallow minced meat and had gained 7 lbs. The improvement was maintained for eighteen months, when a relapse required a renewal of the electric current, and she can now take solids without having to pass a bougie. The electrical treatment consisted in applying the constant current (10 increased to 15 milliamperes) for ten minutes, followed by the Faradic current, and subsequently the combined current for four to six minutes. The positive pole was applied over the nape of the neck, and the negative was connected with an intra-gastric electrode, which was passed down to the stricture, twelve inches from the teeth.

Mr. CHARTERS SYMONDS showed a case of Ununited Fracture of the Tibia and Fibula. A man, *æt.* 40, came to the hospital with an ununited fracture of the tibia and fibula and some fixation of the knee. Two

operations were performed; the first corrected the deformity, and brought the parts so accurately together that wiring seemed unnecessary. Primary healing of the wound resulted, but there was no union of the fracture. At the second operation the ends were found lying in apposition, with the medullary canals closed. The fibrous material covering the ends was cut away, so opening freely the medullary canals, and the ends joined by thick wire. The wound healed by first intention, but six weeks later there was free antero-posterior movement, so in December, 1904, a walking apparatus was fitted, and there has since been marked progress towards union.

Mr. OPENSHAW thought that the bone was still ununited. He could vouch for the efficacy of the splint described, especially in recent fractures of the tibia and fibula.

Mr. CHARLES GIBBS showed a Multiple Circumscribed Fibrous Masses in the Corpora Caverosa. A man, *æt.* 48, in June, 1904, during coitus felt a click on the dorsum, three inches from the tip of the penis, and subsequently had upward chordee, and was impotent. In October, 1904, there was a solid mass of fibrous tissue on the dorsum of the penis like cartilage, one inch square, with a dense cord running backwards from it. Later the fibrous mass became less defined, but there was an increased hardness of the corpora cavernosa on the dorsal aspect. Upward chordee ceased; no erection occurred in the pendulous penis. There are now two large masses of fibrous tissue in the corpora cavernosa, just in front of the scrotum; also there is the dorsal mass which is softer than before. Erection partial and painful. He was cut for stone when a baby, and does not emit in coitus, but there is no visible scar. He had a small sore on the penis thirty years ago.

Mr. CAMPBELL WILLIAMS considered that the condition was due to hæmorrhage and not to gout.

Mr. GIBBS replied.

Mr. CHRISP ENGLISH showed a case of Traumatic Cephalhydrocele. A boy, now *æt.* 8½, when six months old fell twelve feet on to a stone floor, and was unconscious for three hours. There was no bleeding from the ears, nor nose, nor were there convulsions, but five hours later a swelling rapidly formed on the left side of the head. This swelling had persisted, though now somewhat smaller in proportion to the size of the head than formerly. The boy had been quite bright and intelligent, and is well developed. Except for some pains about the swelling during the last four months, there had been no symptoms from the swelling, which had not been treated in any way. There was marked asymmetry of the head owing to the abnormal prominence in the left parietal region. In the left parietal bone an elliptical opening was readily felt, running from a point two and a half inches vertically above the auditory meatus towards the lambda, and measuring four inches in length and two inches at its widest part; the bone surrounding this gap formed an elevated and irregular ridge. The gap was occupied by a soft swelling, which fluctuated and visibly pulsated; on firm pressure the swelling was partially reducible, and it was then felt that the opening in the dura mater was much smaller than that through the bone.

Mr. W. G. SPENCER showed a case of Abnormality of the Left Testis. The patient, *æt.* 21, has never felt, either in the left scrotum or groin, a testis like the right one. In the upper half of the left scrotum a soft mass hung down, which was drawn up a little when he coughed.

Mr. LEWIN MCGAVIN thought that the condition was one of hernia above an atrophic testicle.

Mr. SPENCER, in reply, said that he did not propose to operate on the case.

Dr. CHAS. BOLTON showed a case of Congenital Absence of Lateral Abdominal Muscles with Enlargement of Bladder and Ureters. The patient was a male infant, *æt.* three weeks. He was the youngest of eleven, and a full term child. No deformities of any description in the family. The mother had one miscarriage, but no still births. She was somewhat

starved during pregnancy, but otherwise healthy. No abnormality could be found in the child except the condition of the abdomen. The recti were present, but there appeared to be complete absence of the lateral muscles. Distended coils could be seen under the skin which bulge out the sides of the abdomen, and appeared to be the distended ureters. The abdominal viscera could be palpated with ease. The left kidney was enlarged. The bladder could be felt as a pyriform tumour, almost reaching the umbilicus, and it emptied when urine was passed, but fulness could still be felt in this position after the act was completed or after a catheter was passed. The child passed urine, but as the prepuce was tight circumcision was performed. The testes could not be felt in the scrotum. There were very few longitudinal grooves in the mid-line and the umbilicus was slit like. Some bleeding occurred from the umbilicus on one occasion. The diaphragm and remaining muscles of the body were normal.

Dr. BOLTON referred to a recent paper by Dr. Garrod in which three of the features were associated with the absence of abdominal muscles; these were, hypertrophy of the bladder, a linear, scar-like umbilicus, and undescended testicles.

ROYAL ACADEMY OF MEDICINE IN IRELAND. SECTION OF OBSTETRICS.

MEETING HELD FRIDAY, APRIL 7TH, 1905.

The President, Dr. ALFRED SMITH, in the Chair.

SPECIMEN.

Dr. JELLETT showed a Fallopian tube with calcified nodules filling its lumen, the remains of tuberculous infection.

Drs. Rowlette, Tweedy, Purefoy, Professor McWeeney and the President, took part in the discussion and Dr. JELLETT replied.

RUPTURED TUBAL PREGNANCY, WITH DEMONSTRATION OF CHORIONIC VILLI.

Professor E. J. McWEENEY showed this specimen which had been removed by Mr. Blayney at the Mater Hospital from an unmarried girl, *æt.* 24, who had been suddenly seized with acute abdominal pain and collapse. The abdomen on being opened 24 hours after onset of symptoms was found to contain much blood. The ruptured tube was discovered and removed, whereupon the patient made an uneventful recovery. The sac was about the size of a large hazel-nut and lay near the uterine end of the tube which was widely ruptured and contained a mass of blood-clot to which some whitish shreds adhered. The foetus was not seen. Microscopic sections showed the shreddy matter to consist of tufts of chorionic villi, some of which were enclosed in a thin epithelium-covered membrane of doubtful nature. The stroma of the villi exhibited marked metachromatism on staining with Ehrlich's hæmatoxylin. It was covered with a double layer of cubical cells (Langhans' cells) on the outside of which were scattered without any regularity large multi-nucleated masses of protoplasm (syncytia). In the intervillous spaces were groups of large mononuclear cells without intercellular substance (trophoblastic cells). The mass of blood-clot contained isolated syncytia in its clefts and also large groups of the trophoblastic elements, lying at a considerable distance from the most deeply penetrating villi. The syncytial cells had not as yet become confluent, and were identical in appearance with the multi-nucleated so-called "foreign-body" giant cells found wherever intrusive matter was undergoing absorption. Exhibitor suggested that their function was to cause the natural structures to melt away and thus provide nourishment for the ovum prior to the establishment of vascular connections with the mother. Their nuclei seemed to be proliferation by gemmation, not by mitosis. The mucosa of the Fallopian tube was intact, save at one spot where it was replaced by a fibrinous mass. The delamination of its muscular bundles was apparently being accomplished by swarms of small mononuclear cells resembling lymphocytes. The excellent state of preservation of

the structures mentioned was his chief reason for exhibiting the specimen.

Drs. Purefoy, Jellett, and the President spoke and Professor McWEENEY replied.

Dr. JELLETT read notes on a case of "Labour occurring in a Unilateral Synostic (Nægele's) Pelvis."

Drs. Smyly, Purefoy, Moorehead spoke, and Dr. JELLETT replied.

Dr. E. HASTINGS TWEEDY read the "Report of the Rotunda Hospital for the year 1903-4."

The discussion was postponed until the next meeting of the section.

THE SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

MEETING HELD APRIL 14TH, 1905.

MR. R. CLEMENT LUCAS, in the Chair.

Dr. C. W. CHAPMAN read notes on a case of "Hysteria" in a Girl, *æt.* 10. At first she suffered from anorexia, excitability, and morbid affectionateness for her parents. Gradually the excitability was replaced by listlessness, so that she hardly answered questions. Subsequently she was seen by two other physicians who diagnosed cerebral tumour. The child became bedridden from complete loss of power and sensation in the legs, emaciation and incontinence of urine and faeces. At times she declared she was quite blind. Dreadful screaming fits occurred daily, attracting the attention of passers-by. She was then separated from her friends, put in a hospital, and made a rapid recovery. Twenty years had elapsed since, without any return of the former symptoms.

Mr. LUCAS thought that some cases of enuresis should be regarded as hysterical.

Dr. G. E. SHUTTLEWORTH held that certain peculiarities about their food sometimes shown by children of neurotic parents were hysterical in origin. He thought that hysterical symptoms in children were fairly common.

Mr. R. C. DUN (Liverpool) described a case of "Congenital Deformity of both Forearms" in a boy of five months, in a position of complete pronation. A bridge of bone extended downwards and inwards from the neck of the radius to the upper end of the shaft of the ulna. There was absolute fixation, and the other muscles acted properly. He had been unable to find any record of a similar condition.

Mr. C. BATCHELOR (Staines) reported a case of "Exophthalmic Goitre" in a girl, *æt.* 3, daughter of healthy parents in a good position of life, and without any evident cause. The earliest signs were prominence of the eyes and attacks of passion. Later there was distinct enlargement of the thyroid, and the attacks of passion became more frequent. The heart's action was accelerated. A year after the onset the exophthalmos was very marked, pulse 120-140, marked carotid pulsation, breathlessness on exertion, von Graefe's sign, but no tremors. She died from exhaustion, after an attack of diarrhoea and uncontrollable vomiting, at the age of six years and four months. Admirable photographs of the case were exhibited.

Mr. SYDNEY STEPHENSON pointed out that three cases of the disease had been brought before the Society, but none under twelve years of age.

Dr. G. SUTHERLAND referred to the rapid course of the disease. Many diseases which were chronic in adults were very rapid in their course in children. The absence of acute mental symptoms and the termination in acute abdominal trouble were points of interest.

Dr. EDMUND CAUTLEY showed a specimen of "Verrucose (infective) Endocarditis of the Aortic Valves and Aorta," from a boy, *æt.* 3. No other valves were affected. The child was admitted to hospital as a case of meningitis, due to injury. The diagnosis was established during life by the presence of a loud, aortic, systolic murmur, an enlarged spleen, irregular pyrexia, and absence of cerebral symptoms usual in meningitis. The aortic valves were converted into thick, hard, warty masses. The aorta was dilated,

and in it was situated a large circular patch of chronic induration, like a sessile wart. It was softened at the side, permitting the effusion of blood into the pericardium, the effusion being the direct cause of death. In the base of the wall of the left ventricle there was an infarct, the size of a small walnut, beginning to break down. Another infarct was found in the spleen. From the condition of the valves, Dr. Cautley thought that there had been a primary congenital lesion, and that the terminal infection was of recent origin. The child had been in another hospital some years before for a "weak heart." The left ventricle was hypertrophied, but not dilated.

Mr. R. C. DUN showed a specimen of "Congenital Stricture of the Oesophagus" from a boy, aged 31 months, symptoms having begun at eighteen months. The obstruction was $7\frac{1}{2}$ inches from the teeth. The first symptoms were vomiting and wasting. Gastrostomy was done at the age of twenty months. The child subsequently died from marasmus. The specimen showed a simple stricture an inch above the diaphragm. In two other cases, one reported by Dr. B. Rogers to this Society last year, and the other published in the *Lancet*, January 7th, 1905, by Dr. Whipham and Mr. Fagge, the position of the stricture was the same as in this instance. In none had the symptoms appeared before the twelfth month.

Dr. R. T. WHIPHAM stated that a research into the literature had only enabled him to find six analogous cases.

Mr. R. H. WHITELOCK (Oxford) read an interesting paper on some points in the diagnosis and treatment of "Appendicitis in Children."

A long and good discussion took place in which Mr. Lucas, Dr. Percy Lewis (Folkestone), Dr. C. W. Chapman, Mr. Lockhart Mummery, and Mr. R. C. Dun took part.

SHEFFIELD MEDICO-CHIRURGICAL SOCIETY.

The President, DR. ARTHUR HALL, in the Chair.

Dr. W. S. PORTER showed a case of "Progressive Muscular Atrophy."

Dr. J. MASON showed a case of patent branchial cleft. The patient was a boy, *æt.* 11. There was a small opening in the neck at the outer border of the sternal portion of the sterno-mastoid muscle about $\frac{1}{2}$ inch above the right clavicle, which admitted a fine probe for a distance of about two inches in an upward direction. The sinus secreted a small quantity of thick mucus.

Mr. SINCLAIR WHITE showed (1) two specimens of fibroids of the uterus, complicated with pregnancy. In each case pan-hysterectomy had been performed, and the patient made a remarkably good recovery. He was impressed with the ease with which the uterus was removed owing to the great laxity of the broad ligaments. (2) An ovarian abscess removed from a married patient, *æt.* 24. There was a history of pelvic pain for four months, with evening pyrexia and rigors. Bimanually a tender, fluctuating, irregularly round mass could be felt on the right side of the uterus. The diagnosis of septic tubo-ovarian mischief was strengthened by a history of gonorrhoea in the husband. It was not possible, without undue force, to bring the ovary to the surface until the Fallopian tube and broad ligament had been ligatured and divided near to the uterus. The diseased mass was eventually removed without rupturing the abscess, and the wound healed aseptically. The Trendelenburg posture, conjoined with gauze packing, greatly increased the ease and safety with which these growths could be removed. (3) A dermoid cyst of the right ovary removed from a patient, *æt.* 13. The tumour had been observed for one year, and had been tapped before coming to hospital. It was of a lustreless dark brown colour, and everywhere adherent. The pedicle was twisted on itself to the extent of two complete turns, and had implicated the vermiform appendix in the twist. The patient made a good recovery. (4) A knee-joint showing the typical pathological changes produced by

osteo-arthritis. The specimen was excised from a patient, æt. 31, who had been crippled by it for several years. Although non-articular osteo-arthritis involving the knee-joint came within the recognised sphere of influence of the operating surgeon, the exhibitor had signally failed in two previous cases to obtain a useful limb after excision. The present case was too recent to say how it would turn out. (5) A series of specimens of enlarged prostate removed by the supra-pubic route. (6) Five specimens of mid-rectal cancer excised by Kraske's method. He was in favour of a preliminary iliac colostomy in most cases. By introducing the hand through the abdominal wound it was easy to decide whether or not the growth was removable, and, what was of equal importance, whether there was secondary infection of the mesenteric glands. (7) Three specimens of partial gastrectomy for cancer of the pyloric end of the stomach. In one case in which he had used Murphy's button it was necessary to perform gastro-jejunostomy three months later on account of stenosis of the opening. (8) Two specimens of excised cæcal cancer. In both cases he had obtained a good result by lateral implantation by means of Murphy's button. One half of the button was passed into the colon before closing its cut end. A small opening was then made two inches above, through which the shank of the button was protruded. The second half was sewn into the end of the ileum. (9) A gangrenous ovarian tumour with a twisted pedicle. (10) A tuberculous kidney containing a large branched calculus, removed from a man, æt. 56. Symptoms of renal calculus had existed for twenty-eight years. He thought tubercle was very apt to develop in old standing cases of renal calculus.

Mr. ARCHIBALD CUFF read notes of, and showed the specimens from the following cases: (1) Resection of cæcum and ascending colon for carcinoma in a woman, æt. 38. (2) Resection of cæcum and ascending colon in a young woman, æt. 25. The junction of the small and large bowels was effected by implantation of the small bowel into the wall of the large and suture after Watson-Cheyne's method. (3) A case of large hydatid of the liver treated by drainage and packing through the peritoneal cavity in a woman five months pregnant. Recovery was rapid and the pregnancy undisturbed. (4) Ruptured tubal gestation; the pregnancy had commenced during suckling, and in a period of amenorrhœa the rupture was accompanied by a discharge of blood per vaginam, which, but for the considerable pain present, the patient would have considered a normal period.

Mr. R. FAVELL read a paper on the "Treatment of Uterine Fibroids."

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, April 29th, 1905.

REVULSION AND ARTIFICIAL ABSCESSSES.

MODERN therapeutics have not excluded the old-time revulsion, such as blisters, cupping, cautery, actual or potential, which are still considerable factors in the treatment of certain maladies. They all act somewhat in the same manner, stimulating the solid elements of the blood, the corpuscles, and especially the white corpuscles and leucocytes which play such an important rôle in the organism of man and animals.

Artificial abscess is a kind of revulsion much less known or employed, and worthy of a brief notice.

Fochier was the first to draw the attention of the medical world to the effect of artificial abscesses on certain maladies and discovered the *modus operandi*. It consists in injecting into the exterior part of the thigh one or several hypodermic syringes of essence of turpentine. In three or four days an abscess is found but rarely opens of itself; it must be incised as soon as fluctuation is felt and dressed antiseptically.

In the maladies for which the abscess is provoked the reaction is rapid and intense, the prognosis is favourable; if, on the contrary, the turpentine produces no effect, a fatal issue is imminent, as the organism has

no longer the strength to react against the local irritation.

The maladies in which these abscesses have shown their efficacy are: pneumonia, broncho-pneumonia, puerperal infection, pleurisy, typhoid fever, malignant scarlatina, poisonings, etc.

How do they act? By what mechanism are the toxic substances which threaten the deep organs, and, of much more importance the life of the patient, attracted to the skin? For M. Carles it is by migration of microbes as well as white corpuscles to the local lesion. The stream of white corpuscles is due, above all, to the chemico-toxic sensitiveness of these corpuscles, the essence of turpentine acts upon them as a microbial toxine.

According to Arnozau it was not only the microbes dragged along by the phagocytes which perished in the artificial abscess; it was the phagocytes themselves which succumbed in the struggle between the toxins and the microbes, constituting the waste so dangerous to the economy when they wander through the blood torrent or accumulate in inflammatory centres. It is this waste that constitutes the extensive suppuration which modern antiseptics has suppressed in wounds and operations, but which can be found in grave pneumonia, peritonitis, etc. 'To the white corpuscles is added sometimes red corpuscles, destroyed in large quantities, as in poisoning by oxide of carbon, and which are found in artificial abscesses, giving a chocolate colour to the pus.

ACUTE CORYZA.

This troublesome affection is frequently rapidly alleviated by the following powder:—

Salicylate of soda, $\frac{1}{2}$ oz.

Dover's powder, 30 grs.

Essence of peppermint, 11 min.

Divide into 10 powders. One every 3 hours until relief is obtained.

WARTS.

Salicylic acid, 30 grs.

Resorcine, 30 grs.

Elastic collodion, 4 drachms.

Paint on the wart every night for a week.

POST PARTUM HÆMORRHAGE.

It frequently happens that a practitioner is called to a case of *post partum* hæmorrhage without having had any warning as to its nature, and consequently finds himself without the classical means of arresting it.

Dr. Gilby, of Nîmes, in two or three cases of this kind published by him, proves how, by very simple means, the medical attendant can be equal to the occasion. A pint of vinegar, a tablespoonful of salt, and two clean handkerchiefs constitute all that is necessary. He begins by making the patient drink off a half a glass of vinegar, then he steeps one of the handkerchiefs in a glass of the vinegar, and having squeezed it a little, he introduces it into the vagina through the speculum. Leaving the plug *in situ*, he orders an enema of salt water (one tablespoonful of salt for one quart). The hæmorrhage is arrested immediately. The hemostatic properties of vinegar, like those of any acid, are well known, but not sufficiently employed, while the saline enema strengthens the pulse and raises the tone of the patient generally.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, April 29th, 1905.

THE Congress for Innere Medizin was held in Wiesbaden under the presidency of Prof. Erb, of Heidelberg. In his introductory address he spoke some stirring words on professional status and professional aims and aspirations. He said the profession of medicine was at present depressed to the status of the artisan, and hence struggles for appointments and doctors' strikes. Even medical men were smitten with the reckless struggle after money, the accumulation of riches and limitless capitalism. Trade and industrialism now also attacked curative institutions and sanatoria. Many medical men, as proprietors of

such institutions, were playing a double *role* as medical directors and landlords of hotels and their aims were not kept sufficiently distinct. The whole range of medicine could no longer be mastered by the individual. The pathology and therapeutics of phthisis, of diseases of the heart and stomach, intestinal diseases, diseases of tissue change and infection, and especially the medicine of nerve diseases tended to separation. The medicine of nerve diseases was justified in a particular speciality, in the formation of its own departments, out-patient rooms, and academic representatives, but internal medicine must ever be associated with it. For instruction in psychiatry the so-called nerve diseases with the exception of certain borderland cases were superfluous for instruction in medicine, yet for the information of the physician they were indispensable. Nerve medicine belonged to the medical clinic. In the borderland both classes of clinics should participate in accordance with certain principles.

THE PRESENT POSITION OF THE DOCTRINE OF HEREDITY IN BIOLOGY.

The subject was introduced by Hr. Ziegler, of Jena. The conception of heredity, he said, became more accurate and was more sharply defined by Wassermann's theories; but a better knowledge of the processes had been arrived at by the maturation of ovum cells and seminal cells, and thereby the biological significance of the processes of fructification were better understood. Two processes must be separated from true heredity—(1) the passage of excitors of disease (for example, bacteria) from the parent into the germ cells or into the embryo, and (2) damage to the germ cells by poisons or abnormal products of tissue change, where the parental organism was charged with either of them. The process of heredity was not the same in lowest organisms (*Botista*) as in the higher animals and plants. In the first the process consisted in simple cell division, but, in the higher organisms, special cells, ovular and seminal cells were destined for the formation of the new individual. The nuclei of these cells contained, like all cell nuclei, chromosomata, that is, colourable forms appeared in the cell divisions, distinct in form and definite in numbers, and these as regarded heredity were of extraordinary importance. The mature ovular cell contained the same number of chromosomata as the seminal cell, whence it came that as much hereditary influence was due to the mother as to the father. The cell out of which the individual was made, the fructified ovum cell, had the half of its chromosomata from the father, the other half from the mother. This peculiarity was continued in the cell division of the later formed cells, so that the same held for all the cells of the organism. The mingling of the paternal and maternal chromosomata exercised its influence over the whole of the organism that was to be, and it was in this way that the union of the peculiarities of both fathers and mothers still took place. The effect of the mingling (*amphimitis*) was best seen in the crossing of two different kinds of animals, or different varieties of the same species. The offspring generally showed a mixture of the peculiarities of the parents; sometimes, however, a reversion was seen to a grandfather or a grandmother, or even an older stem-form. Special importance was laid upon Mendel's law relating to a certain form of reversion. For an explanation of this process of inheritance one must consider more fully the behaviour of these chromosomata in the maturing of the ovular and seminal cells. As the ovum cell in its maturing formed the so-called direction bodies (pole cells) and so, in a certain way, four cells (three quite small and one large) proceeded from the cell, so out of every seminal mother cell four seminal cells were formed. The relation of the chromosomata was the same in both cases. So-called groups of four were formed, consisting of four globular or band-shaped bodies. Of these four particles, two sprang from the paternal and two from the maternal side. In the ripe ovular cell or in a seminal cell one particle out of the four at least succeeded, and with every group of four it was quite a matter of accident which one of the four particles was selected. The germ cells (ovular

or seminal cells) of an individual might therefore be different, inasmuch as one would contain more paternal chromosomata and another more of the maternal, the whole total of the chromosomata being always the same. As now in the procreation of every new individual a different combination was formed, an explanation was forthcoming of the different qualities of children of the same parents. If the paternal, or the maternal, chromosomata were strongly predominant in the germ cells a reversion to the grandfather or grandmother would be easily understood. The constitution of the human being and the associated disposition towards any disease was inherited from its forerunners. Here also the mingling of the paternal and maternal tendencies played a leading *role* and often led to a reversion to grand-parents. The whole characteristics of the body and of the mind were dependent on heredity and this heredity had all the power of a law of nature.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, April 29th, 1905.

MERCURY IN SYPHILIS.

FEDTSCHENKO has been experimenting with mercury in the treatment of syphilis, and finds that our administration of the drug is very empirical and uncertain in its results, and not always in proportion to the quantity applied. In 150 cases which he has tabulated, not more than 25 per cent. or 30 per cent. is absorbed by the skin, which is best combined with resorcin or vasogen.

EXAMINATION OF BLOOD.

Klug and Nonnenmacher, who have been investigating the different results of blood examination, warned the members of the Physiological Society against blood examination without knowing the conditions under which it is collected, which has an important influence upon the results. The blood is not constant at any time of the day or night in its composition, and therefore it is difficult to form a diagnosis from a single examination. In addition to the period, the very site from which the blood is abstracted alters the results, as the points of the finger or the lobe of the ear will differ from another part of the surface of the body.

The relative number of white and red corpuscles will be greatly altered by the ingestion of food, the movement of the body, or the condition of the mind; perfect repose will reduce the number of red corpuscles, while going up and down stairs may increase in the same person the number from five million to six million. Moving actively about the room will produce a similar result. They have found, however, that increase of blood pressure raises the number of erythrocytes in the blood plasma, and that these two factors vary in constant proportion to one another or, in other words, run parallel to one another.

In the case of exercise the white corpuscles increase at a greater rate than the red corpuscles; while the same disproportion exists when repose commences, as the internal organs absorb a large number of the leucocytes. Another important point was noted in the course of the lecture in relation to the circulation which greatly affected the results. If the hand were held up when taking the blood for microscopic examination, again lowering the hand and taking another sample of blood, the two results would be so different as to lead to the belief that the two samples were from very different constitutions. Temperature, from what has been said, always plays an important part in the results.

We now see the wisdom of Winternitz departing from the usual sites of abstracting blood—the lobe of the ear or the point of the finger—and going to the abdomen for his samples for testing, where there is more likelihood of obtaining a greater accuracy in the results.

CUTANEOUS ATROPHY.

At the Gesellschaft der Aerzte, Neumann exhibited a man, æt. 54, who for twenty-five years has had patches of skin over the body about the size of the hand of a livid red colour, while other patches were of a white, glossy nature like cigarette paper, where the epidermis seems to have been shed, while other places had a dark brown pigmentation with a thickened condition like ichthyosis. Subjectively the patient complained of nothing but itching, which was always very light. He assured the members that he had only seen two other such cases, which he considered to be idiopathic.

Microscopic examination showed inflammation in the upper layers of the cutis which destroyed the follicles and papillary bodies, first causing hypertrophy, but, from its chronicity, ultimately ending in atrophy of the tissue.

GASTRIC CARCINOMA.

Habeser brought forward a woman, æt. 43, on whom he had operated by the duplicated method for carcinoma of the stomach. When she entered hospital a large irregular tumour was to be found at the pyloric end of the stomach. The tumour, about the size of a man's fist, was movable, but the patient being in a dangerously emaciated condition and weak, the radical operation could not be undertaken at once. It was therefore resolved in the first place to perform gastro-enterostomy retro-colica posterior. For twelve days after the operation the patient was sustained by rectal nourishment, and greatly improved, which encouraged the second operation of resecting the pyloric end of the stomach with the tumour. The patient speedily recovered and the wounds healed up without any reaction, and within the last two months she has increased in weight 8 kilogrammes—17·6 pounds.

ATROPHY OF THE GASTROCNEMIUS.

A case of a man, a tanner, æt. 25, was brought forward by Bum, having received an injury to his right foot from the falling of a bale of skins. Shortly after the foot began to swell and assumed a distorted appearance. This was rapidly followed by atrophy of the gastrocnemius and distinct broadening of the tendons at the heel with particular œdema in the tendon of Achilles. From these symptoms it was concluded that the patient suffered from a compressed fracture of the calcaneum. This was confirmed by the Röntgen rays, by which it was observed that a splinter of bone lay on the under surface of the calcaneum, where it caused a good deal of pain. No other dislocation or fracture could be observed. This is the third case of its kind recorded in medical literature.

Operating Theatres.

ROYAL FREE HOSPITAL.

OPERATION FOR SEPARATION OF THE LOWER FEMORAL EPIPHYSIS.—Mr. T. P. LEGG operated on a boy, æt. 7½, who had been run down and knocked over by a cab; the wheel passed over the lower part of the left thigh, which was found to be fractured just above the condyles. The limb was put up in a splint, and allowed to remain for three weeks. At the end of this time the splint was removed and it was found that the fragments were united in a bad position, the lower end of the upper fragment being displaced outwards, so that it lay on the outer surface of the external condyle; the lower fragment was drawn upwards and inwards, there being fully an inch of shortening. There was considerable swelling in the left knee-joint, due to effusion. Owing to the bad position of the fragments, and on account of the lower end of the femur being that from which growth in length chiefly takes place, Mr. Legg decided to operate in order to put the fragments into apposition. An incision four inches long was made on the outer side of the thigh, beginning over the external condyle, and the periosteum was detached at the site of the fracture with a con-

siderable quantity of external callus. The union of the fractured surfaces was broken through by a periosteal elevator; it was then found that there was a separation between the external condyle and the lower end of the shaft, the line of separation passing between the epiphyseal cartilage and the shaft. From the inner end of this line of separation a fracture extended obliquely upwards and inwards through the lower end of the shaft. After the deformity had been reduced the fragments were securely held together by a screw passed through a hole which had been previously made. The periosteum was sutured in position, and the external wound closed, the limb being put up on a back splint. Mr. Legg said that there were two methods of treating these cases of separation of the lower epiphysis: (1) by flexing the limb; (2) by operation. Both methods gave very satisfactory results, but operation should be adopted when the deformity cannot be rectified by the first method. Another class of cases, he thought, called for operation, namely, when the separation of the epiphysis was compound; in these cases it was not uncommon to find various complications, and they formed a class different to that operated on. The importance of the separation of the epiphysis, he remarked, arose from the interference with growth and function of the parts concerned. If the fragments were left in their displaced position the femur would probably become much deformed, so that considerable shortening, and possibly interference with the movements of the knee-joint, would result. In such a joint as the knee, this would, he pointed out, be a serious drawback to the patient, but in such a joint as the elbow, although the deformity is sometimes marked, the movements and utility are quite good. He also pointed out that the two fragments overlapped one another obliquely and could be more firmly fixed by the use of a screw than by a wire; moreover, the screw was more easily applied. As regards the after treatment, there was generally a certain amount of stiffness of the joint and some limitation of movement. This would be treated by massage and passive movement, begun about three weeks after the operation. The patient left the hospital eight weeks after the operation, able to walk quite well, with very little stiffness and no shortening of the limb.

University of Durham.

THE following candidates have passed the First Examination for the Degree of Bachelor in Medicine.

1. *Elementary Anatomy and Biology, Chemistry and Physics.*—Chas. W. Greene, R.C.S., Ireland, Honours—First Class. Eldred C. Braithwaite, College of Medicine, Newcastle, Honours—Second Class.

Pass List.—Charles M. Brown, Charles E. L. Burman, Bloomfield G. H. Connolly, Cyril J. Henderson, William Sacco.

2. *Elementary Anatomy and Biology.*—Ronald M. Angus, Harriett A. R. Apps, Wilfred Barkes, Alexander Hay Bower, John G. Campbell, B.A., Harold A. Cooper, Leslie W. Evans, Francis H. Fawkes, Reginald C. H. Francis, Patrick A. Galpin, Cyril Gray, Arthur C. Greene, John P. Jackson, Annie Viccars Mack, Ernest P. Martin, Ruth Nicholson, John H. Owen, Frederike Rahtkens, Robert Raffle, Charles E. Reindorf, Matilda Ann Sinclair, Theodore W. Stallybrass, Harold W. Sykes, George H. Wood, Alfred A. Woodhouse, B.A.

3. *Chemistry of Physics.*—Jacques M. L. F. Coquelin, Claude Percival R. Harvey, Edward P. L. Hughes, Stanley L. Randolph, Lennox M. Stewart.

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The Medical Press and Circular.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, MAY 3, 1905.

MODERN ADVERTISING AT ST. BARTHOLOMEW'S HOSPITAL.

THE present generation has witnessed a revolution in the methods of journalism. Seriousness to a great extent has given way to sensation-mongering, and responsibility to catchpenny hoodwinking and knavery. The most staid and respectable of our old-established newspapers have abandoned their former position step by step, and have become more and more engulfed in the vortex of unscrupulous, greedy and grasping yellow journalism. The average citizen, whom we may still credit with a conscience, can only gasp with amazement and wonder where it will all end. He has seen the spirit of sophistry and evasion of plain issues overflow into the sphere of politics, so that it is no longer possible to get a plain answer to a plain question upon the most vital issues of party government. Now, it would seem, he is destined to see the medical charities following methods calculated to put the less base yellow journals to the blush. The allusion is to a series of articles that have, during the past few weeks, been published in the advertisement columns of the *Times* under the title of "The Theatre of Life." They are written in finished literary style, and it is signified that "These notes upon St. Bartholomew's Hospital were prepared by a member of the advertising staff of the *Times*, and the information supplied has been verified by independent investigation." The matter and the manner are handled just as one would expect from a lay writer under those circumstances. No detail is omitted that can arrest and hold the sympathy and the attention of the reader, with a view to the ultimate opening of his purse-strings. No. IV. of this extraordinary series deals with surgical operations at St. Bartholomew's. It describes a familiar little *cortège* passing across the great quadrangle. "The stretcher, with its recumbent

figure warmly wrapped in the red blanket, is carried with the gentleness and even steps that its bearers have acquired in the long bearing of such burdens. Alongside walks a sister and her attendant nurse. It is a patient on the way to or from the operating theatre, and the meaning of the errand rivets the eye to the little company and strangely stirs the mind." Then follows a column dealing with the wonders of modern surgery, the administration of anæsthetics, the method of summoning the surgeons from Harley Street, the inevitable appendicitis, and the consent of patients to operative procedures. "Decayed bones, the excision of tumours and cancers, tracheotomy and trephining, the wiring of aneurisms, and the grafting of skin," are touched upon with delicate literary craft—as far removed from the "raw head and bloody bones" of a former generation as a clumsy velocipede from a modern racing motor. The student fainting at his first sight of an operation is sketched in a few masterly sentences. The melodramatic climax, however, comes fitly at the end with the description of an actual operation performed by a gentleman and his assistants, described as follows:—"The short, rather stoutish man, black-bearded, and his bald crown of a shining pallor is—the famous surgeon, whose case this is. With him are the house surgeons, clean-shaven, lithe, alert men of astounding youthfulness of appearance." It may be asked, in passing, what the black-bearded surgeon and his *confreres* of St. Bartholomew's think of the gross indignity to which they have been thus subjected, and what steps they have taken to protect themselves against such an occurrence in the future. The *Times'* ready writer then describes the high-pressure copper boiler, sponges, sterilising processes, and other details of the operating theatre. Nor does he omit mention of the instruments, which are to him "a wonderfully subtle array of scissors, needles, strangely-curved instruments, and hooks, lances and saws, each in duplicate," and so on. This astounding document ends with the following passage, which reminds one of the style of the *Newgate Calendar*:—"The figure on the couch is now deep in blessed unconsciousness, the nurses removes (*sic*) the covering, there is a clink of steel on the glass table, the surgeon steps forward . . ." Here the veil is dropped, and a foot-note tells the date on which the narrative is to be continued. We submit that advertisement of this kind is unworthy of the honourable traditions that are usually associated with the ancient hospital concerned. Last year we protested strongly against the cavalier way in which the question of the removal of St. Bartholomew's to a suburban site was burked by the Mansion House Committee. Radical changes have since taken place in the management of the hospital, but the appearance of the touting advertisement under notice shows that further changes are required. The attention of the King Edward, the Sunday, and the Hospital Funds may be called to this point, and especially to the great cost of repeated double-column

advertisements in the *Times*, written by a member of the staff of that journal. The average subscriber would rub his eyes were he told how much of his money had been thus sunk in costly advertisements. The whole incident forms a scathing satire on modern hospital methods.

DUST.

THE thought of the coming summer, while it is concerned chiefly with the pleasures of that season, draws with it also a certain notice of the drawbacks usually accompanying it. Among these dust is obviously not one of the least. In a dry season the plague is at times almost intolerable, and even the pleasure of the occasional fine week of a wet summer is marred by it. Wherever one lives, whether in town or country, one can hardly escape. In town, indeed, the half-hearted efforts of the watering-cart have a certain effect, but nevertheless our houses are invaded, our curtains, furniture, and papers soiled, and the temper of our housemaids ruffled, by the sudden gusts which sweep the streets in the intervals of the visits of the watering-cart. In some cities, indeed, it is the custom to sweep the streets while dry, and those whom business or belated pleasure keeps out in the small hours of the morning can understand something of the nuisance caused thereby. In the country, unless one live surrounded by fields or inhabit a lodge in some vast wilderness, matters are worse, for, as a rule, the high-roads know not the watering-cart, and the dust collects inches deep. It is still a question whether the use of motor-cars has increased the actual production of dust. The annoyance caused by it has, of course, been increased, for there is no other vehicle which raises clouds of dust to such an extent. On the other hand, it is difficult to see how a broad rubber tyre can grind up the road metal as does a hard iron wheel. We may hope, perhaps, for an entire cessation of the dust plague when all the traffic will have become automobile. At present, however, the problem is how to prevent the formation of dust, and how to keep it laid. The day of water is, we fear, at an end. At best, its effect is but temporary, and it substitutes the nuisance of mud for that of dust. As long ago as 1880, the use of tar was recommended to give a firm surface to a road and to fix the dust, and excellent results have been attained. It has, moreover, a distinct bactericidal effect on the organisms which swarm in the dust of the street. In addition to its expense, tar has, however, certain other disadvantages which tend to prevent its general adoption. It requires a perfectly dry surface for its application, a condition rarely found in this country. Moreover, it leaves the surface in such a slippery condition as to render a declivity so slight as one in thirty dangerous to horses. More recently, petroleum has been recommended and used with good effect. It also has some bactericidal power, but is not so effective as tar. Its effect in fixing a road surface, also, is less

and its expense is a considerable item. Within the last year or two, an article called "westrumite" has been introduced, and as far as one can judge from the tests already made, it promises to prove a more useful agent than either tar or petroleum. It has not, however, as yet had a sufficiently rigorous trial, its chief use having been to prepare roads for motor-racing. Whether it possesses the necessary powers of fixation and durability in proportion to its cost remains yet to be seen. It is said to have no bactericidal power. Up to the present the necessary experiments in the treatment of dust have been chiefly made in France, where the plague is greater than in these countries. It is necessary, however, before deciding on the adoption of any agent that they should all be tested at home, as what is suitable for French roads may not, owing to different climatic and geological conditions, be suitable in England.

LONDON CONSUMPTIVES.

WHEN the question of consumption is under consideration in every English-speaking quarter of the globe, and in most of the principal European countries as well, it is fit and proper that its prevalence in London and the means to prevent that prevalence should be anxiously thought over. Clearly if measures can be taken that will markedly reduce the incidence of a disease that affects some forty thousand people in London, arguments for not adopting those methods must be very strong to carry conviction. The Incorporated Society of Medical Officers of Health have long had this matter before them, and, indeed, having regard to the immense importance of consumption from the point of view of the general health of the community, it would be strange if they had not. The conclusion at which that society arrived some time ago was that one of the chief steps to be taken was the provision of sanatoria for tuberculous patients, and that the authority to undertake the work was the Metropolitan Asylums Board. The Board was approached, but they had already so many irons in the fire that they did not see their way to add to their responsibilities. In 1903, finding opinion pressing, they took the sensible course of referring the matter to the Local Government Board, leaving it to them to institute the necessary inquiries and to advise as to the course to be pursued. The Local Government Board are well in touch with medical opinion on public health questions, and, moreover, know the political and financial responsibilities involved by them. The fact that they have not yet moved shows that the course urged is attended with great and special difficulties. A powerful deputation, organised by the Society of Medical Officers of Health, and constituted of representatives of the National Association for the Prevention of Consumption, the Royal Colleges, the Sanitary Institute, the National Health Society, the Hospital Saturday and Sunday Funds, and the Charity Organisation Society, waited on the Metropolitan Asylums Board last month to lay before them

the necessity of providing sanatoria. A combined deputation of these various bodies naturally carried much weight, and the Board will now have to consider the matter as one of grave and deep moment. We hope they will arrive at a decision which will be neither immature nor ill-advised. To diagnose a disease is one thing; successfully to treat it, another. Everyone agrees as to the immensity of the evil; everyone has not yet seen the efficacy of the proposed treatment irrefragably established. It has been generally accepted by the profession that for consumptives a rational, simple life with beneficent supervision is better than an artificial one in which the constitution of the patient is hampered in its struggle with disease by the lack of vital necessities, such as air, light, and food. The only wonder is that it took so many centuries to realise the most obvious fact that ever obtruded itself under the nose of observers. Moreover, it is held that the segregation of consumptives removes one source of tuberculous infection from the community. From these points it is a long and risky jump to say that in a huge, complex city like London, any large fall in the incidence or fatality of tuberculosis would follow the establishment of a system of sanatoria. Without coincident improvement in the conditions under which people live, that is to say, without a diminution in consumption-breeding factors in people's houses and workplaces, it is problematic if any marked difference would be noticeable if most of London's forty thousand consumptives found themselves in sanatoria to-morrow. Judging from the figures presented by the deputation, something like a third of the total consumptives in the Metropolis already find their way to the Poor-law Infirmaries, and probably one-sixth of the remainder are under treatment in the various chest hospitals and sanatoria in and about London. Although these present agencies are not altogether ideal, it is reasonable to suppose that by removing the consumptive from his habitat, they do something to keep down the foci of disease which are furnished by ignorant or careless patients, living at home. So that as regards centres of infection, a sanatorium system would have to reach very large proportions before it could be expected, on the most favourable showing, to exhibit any diminution in the number of cases in which proximal infection was responsible for the attack. As to the economical argument that the sanatorium experiment would pay by saving the lives of workers who would die if left to existing agencies, it can only be accepted with reserve. *Vixere fortes anti agamemnona*; consumptives were "cured" before sanatoria were invented. And they continue to be "cured" still without going to sanatoria. It must not be forgotten that the sanatorium only offers a mode of treatment, and that although that is the best mode at present known, it is a long, costly, and often disappointing one. Already many sanatorium authorities are expressing their surprise that greater results have not been attained by

their institutions, and some medical men have been bound to acknowledge that the sanatorium makes but little difference to a patient who has a moderately good home and exercises care in his doings. Sufficiently large figures are not yet available for absolute conclusions to be drawn, but such as they are they show that 25 per cent. of cases that now undergo sanatorium treatment—and there is a distinct selection acting in favour of the sanatorium—are dead within four years—a not too encouraging result when it is proposed largely to increase the system at the cost of the rates, especially if compulsory powers, such as Sir William Broadbent would like to see vested in the Metropolitan Asylums Board, are to be used to deal with consumptives. It would be in the interest of medicine and of the consumptive if a thorough, searching inquiry were made before any large scheme of sanatoria was designed for London, for disappointment and even discredit are likely to ensue if the promoters embark on such a project with too sanguine views as to what it is likely to accomplish.

Notes on Current Topics.

The Election of Direct Representatives for Ireland.

DR. LEONARD KIDD, of Enniskillen, who has come forward as a provincial candidate for the post of Direct Representative on the General Medical Council, has issued a lengthy address to the medical profession in Ireland. The general tone of the address, as well as the reason for Dr. Kidd's candidature, is shown in the following quotation, which he has introduced:—"The manifold trials and difficulties with which medical practitioners are faced have led them during recent years more and more strongly to feel that they should receive more active support and assistance from the governing body of their profession than they now, or in the past, have gained. Yet, looking at the constitution of the Council, they see that it is composed of men, excellent in many ways, but with only five exceptions bound to preserve the privileges and to express the views of the Universities or Corporations which they severally represent; but that it is no part of their legal duty to safeguard the position or to advance the special interests of the great body of the profession—the general practitioners." The reforms, in favour of which Dr. Kidd expresses himself, constitute a formidable programme, and one which might with advantage be pruned so as to bring it into the domain of practical politics. The most important are the increase in the proportion of direct representatives to one-half; a one-portal system of examination, which, however, is to be "qualifying" and is not to replace the "professional examinations held by the Universities and Corporations"; the more stringent protection of the rights and privileges of registered practitioners; the application of the penal clauses

under the Medical Acts to Companies; the improvement of the disciplinary powers of the Council; the licensing of clinical hospitals; the annual delivery at medical schools of a short course on medical ethics; and the direct representation of dentists. In addition to the foregoing, Dr. Kidd holds strong views on the subjects of hospital abuse, contract practice, and the public medical services in Ireland, but he does not consider that they are matters which come within the control of the Council. He especially points out that his address may disappoint the members of the Poor-law Medical Service, as it contains no reference to reform in that service, and he adds, very properly, that "these are matters outside the work of the Council; indeed, to suggest that the Council could mitigate the evils of the service would be mere deception." The address concludes with a list of branches of the Irish Medical Association which have passed resolutions approving of the principle of electing a provincial practitioner, namely, Fermanagh, Donegal, Sligo, Roscommon, Co. Cork, Waterford, and South County Down.

The Huddersfield Experiment.

THE virtue of parochial patriotism is somewhat at a discount in these days, when the glamour of world politics and of Imperial expansion magnetises the imagination of the people of this country, but just as the family is the unit of the State, so are municipalities the units of empires. It would seem, then, that the parish-pump, as having an ultimate bearing on empire-building, is a piece of domestic furniture that may be worthy of the attention of those ardent spirits who concentrate their gaze chiefly on the deeds and misdeeds of our pro-consuls and generals. Huddersfield may not be a name to conjure with in Cabinet Councils, but it has just embarked on an enterprise that may hold in embargo far-reaching factors in the science of Imperialism. This enterprise has for its object the rearing under municipal tutelage of as many as possible of Ruskin's "full-breathed, bright-eyed, and happy-hearted human creatures" for the service of their town. The idea was started by the action of the present Mayor, Alderman Broadbent, a brother of the eminent physician, who, to signalise his year of office, offered a sovereign to every infant born in his ward who attained the age of twelve months. The health committee was impressed with the possibilities of the idea, and after much deliberation they elaborated a scheme for child-rearing which was finally adopted by the Corporation last week. The first item in the programme is a novel one, namely, the offer of a shilling to the first person who notifies the Medical Officer of Health of the birth of a child. This seems likely to afford more amusement for the Huddersfield *gamins* than peace of mind for their medical officer. We can understand the sport inherent in a race to find that official when a shilling depends on success, but in a town in which some six or seven

births occur every day, the medical officer is likely to grow rather weary of awarding the prize to the Johns who outrun the Peters. However, on receiving the news he is to despatch a lady visitor armed with leaflets on baby hygiene to the house of the new arrival, and the ladies are to see that the mother understands how the child is to be brought up. Then a day nursery on a large scale is to be provided for the babies whose mothers are at work, and municipal milk in sterilised bottles is to be forthcoming. The experiment, even with its scientific tinge, is an interesting one, and it will be eagerly watched by other towns. We are not sure what that ogre of enterprising municipalities, the Local Government Board auditor, is likely to think of it.

Responsibility for Locums.

A DISAGREEABLE and disconcerting piece of intelligence comes from the reports of the Clerkenwell County Court. A doctor employed a *locum tenens* to do his work, and the *locum*, being called upon to draw a tooth, pulled the wrong one. A second attempt was made, and this resulted in a good deal of damage to the patient's gums. The patient thereupon sued the doctor for damages, and was finally awarded sixteen guineas. The view of the law will probably be new to most medical men, and it will not add to the pleasures of a holiday to know that they are liable to pay through the nose on their return for any piece of carelessness or want of skill on the part of their substitute. Many practitioners have to depend on their friends' recommendations or the advice of an agency for the selection of a *locum tenens* to leave in charge of their work when they themselves are away, and it happens occasionally that they are supplied with men who, through misfortune or want of character, are not of the type that they would desire. Now, if any man earns his summer holiday it is the doctor in busy practice, and it is very hard lines if he returns home to discover grumbling patients and ill-kept books. If, in addition to these woes, he is to find himself the subject of actions for damages arising out of his *locum's* misdeeds, his case is one deserving of the utmost commiseration. In this case the medical man was ably defended by the London and Counties Medical Protection Society. The incident reveals one more of the innumerable risks attendant on surgical practice.

Waltham Method of Training Nurses.

GREAT as has been the advance in the training of nurses for the sick during the last quarter of a century, there remain yet improvements which are capable of being introduced. Some of these well worthy of notice are at present employed in the Waltham system of training nurses in America. Under this system the probationer is not taken out of her home and sent raw into hospital wards, but she undergoes a kind of pre-probationary training which has many points of advantage. The idea underlying the Waltham

method is that nurses, in the main, are trained in hospital for future practice in private, and that when they leave their *alma mater*, they will not find, even in the houses of the rich, sterility at every corner and instruments at every turn. In fact, that practical nursing consists in doing the best possible thing under the circumstances, and making shift with the most appropriate articles to hand. To acquire this art the probationer, under the eye of an instructor, starts her work in the houses of the very poor, for whom she has to do all that can be done with the scanty material at her disposal. For this purpose she has to turn her hand to everything, from dressing the baby to washing the clothes, and even going out to do the marketing for the family. We are not sure that this system starts at the right end; we mean that the outside work would probably come better after a period in hospital, but of the general advantage to the nurse and to the poor we think there can be no doubt. During the probation the nurse is instructed in various subjects theoretically, and these read rather oddly, including, as they do, chemistry, dietetics, fermentation, putrefaction, marketing and cooking. No doubt they all come in useful, but it strikes one that there is a humorous side to the vision of a nurse, lately primed in atomic weights and Avogadro's law, sallied out to buy two pennyworth of dripping and a packet of starch. But she is likely to be no worse a nurse for all that, and after all it is not more incongruous than the training of doctors who are taught the latest theories of German bacteriologists, but never instructed in the art of wrapping up bottles of medicine or of the right way to hold a baby.

Public Parks in Paris.

THE proposal to diminish the size of the Champ de Mars by one-half for building purposes is naturally producing opposition among the public of Paris, and the Société de Médecine Publique recently devoted an evening to the discussion of the need for open spaces in Paris. It appears that of the three cities, Paris, Berlin, and London, Paris has, in proportion to her acreage, only one-third the amount of open spaces possessed by London, and half that of Berlin. The actual number of parks or squares in Paris is forty-six, in London two hundred, and in Berlin only twenty. It would appear, therefore, that in London the open spaces are best distributed, and in Berlin worst so. With regard to suburban parks, however, London is the worst supplied, having some six or seven hundred acres less than Paris, which is rich in the possession of the Bois de Boulogne and the wood of Vincennes. Berlin, moreover, with her park of Treftan and forest of Spandau, possesses twice as much acreage in suburban parks as Paris and London together. Considering the immense importance to public health of the presence of open spaces in a great city, the tendency in Paris to diminish her already scanty public parks is greatly to be deplored.

Salt and Bright's Disease.

It has several times been put forward that sodium chloride taken in excess is injurious to the subjects of Bright's disease, and alleviation of the conditions arising in the course of that disease has been procured by exclusion of sodium chloride from the diet. It is still a question, however, whether the ingestion of excessive quantities of the salt may act as a causative factor in the production of the disease. It is true, as Castaigne showed, that the administration of large quantities of salt may occasionally give rise to a passing albuminuria; the failure to produce this effect in the majority of cases made, however, the observer suspect that where it occurred there was already a lesion, or at least a predisposition of the kidneys. More recently Silvestri has collected several cases where young subjects, owing to a peculiar craving, consumed large quantities of salt, and subsequently developed typical parenchymatous nephritis. He believes the sequence to be causal, and he thinks that the lesion of the kidney is due primarily to irritation of the epithelium during the elimination of the salt.

Peril in Sweets.

AMONG the minor luxuries of life the sweetmeat holds, and is likely to hold, a prominent place. The pleasure of a certain type of concert or playgoer is incomplete unless the nerves of the palate are at the same time suitably tickled throughout the whole performance by some silver-coated concoction. At the other extremity of the social scale we find the same liking manifested for confectioners' stuff, especially by the young. Oral or gastric fermentation is likely to be set up by the continual bathing of the surface epithelium in a saccharine fluid. Dyspepsia, in one of its many varieties, may easily be produced or aggravated by habitual indulgence in sweet-sucking, particularly in older children and adults. Bearing in mind the fact that the pancreatic ferments are but poorly developed in the infant, it is not at all surprising to find that troubles of digestion, interfering seriously with the nutrition of the body, are common among young children to whom sweets have been too often given by indulgent mothers. This, of course, supposing that the sweets themselves are pure. If dangerous chemicals are introduced in order to increase the brilliance of the colour, matters are rendered worse still. Dr. Rice-Morgan, the Medical Officer of Health for Swansea, in his annual report recently issued, condemns modern sweetmeats in strong terms, and especially refers to the great extent to which they are consumed by the young of all classes. Dental caries is assisted in its development by fermentative changes present in the mouth, and these are distinctly favoured by eating sweets. At the same time it cannot be denied that sugar constitutes a most important foodstuff. Many of the troubles ascribed to eating sweets are due to physical defects, notably, to mouth-breathing and "adenoids."

Mr. Coroner Troutbeck on Needless Inquests.

THE unhappy warfare between coroner and medical profession that has been stirred up by Mr. Troutbeck continues to be waged from week to week in a series of unedifying skirmishes. Having strayed into a position which is regarded by medical men as unjust and indefensible, the Westminster Coroner apparently deems it necessary to belabour medical men with any stick that comes to hand. Last week he was faced in court by one of the outraged medical practitioners in his district, who had refused a certificate of death. Mr. Troutbeck thereupon commissioned his *aide-de-camp*, Dr. Freyburger, a gentleman who, we believe, lives in Hampstead, to perform a *post-mortem* examination. With the usual disregard of ordinary professional courtesy that characterises the conduct of the two gentlemen named, no intimation of the autopsy was conveyed to Dr. Badcock, the medical attendant of deceased. On his entering a public complaint on that point at the inquest, Mr. Troutbeck told him it was quite useless making silly protests. Dr. Badcock later put the case in a nutshell when he stated that the Coroner must expect to have inquests forced upon him if he forced the hands of medical men with regard to *post mortems*, so that practitioners were criticised behind their backs without any opportunity of defending themselves. It is to be hoped that the envy, hatred and malice stirred up by the unwise action of Mr. Troutbeck, and the attempt to foist a semi-official "pathologist" upon the public service will be noted by the London County Council, which controls most of the London coronerships.

Herbalists Hope to Register.

THE absolutely futile state of the British law with regard to quack medical practice was demonstrated to absurdity at a recent inquest held at Farnborough, in Hampshire. A gentleman died under the care of one Mr. Richard Haynel, who holds no medical qualification. The matter was very properly investigated under pressure from the Medical Defence Union, represented by its able and energetic Secretary, Dr. Bateman. From evidence given by himself it appears that Haynel studied under Father Kniepe and other eccentric persons who pose as healers of mankind. In spite of his lack of medical training and qualification, he seems to have found plenty of credulous clients in the United Kingdom, for he claims to have treated 5,000 or 6,000 patients per annum, with only one inquest case. It may be pointed out, however, that patients suffering from serious maladies, who have been in the hands of quacks, usually return to qualified medical men when nearing the end; in other words, when there is no longer any chance of doing any good. The hopeful days of disease are the early ones in which sufferers are apt to trust to the misleading statements of nostrum vendors and quacks. The coroner, at the end of the above-mentioned in-

quest, observed that all persons who treated disease in any way ought to be registered. The counsel or Haynel took up the challenge and said he heartily endorsed that principle, and the herbalists indeed, were promoting a Bill to that effect. The annals of brazen quackery could hardly furnish a more contemptuous disregard of the rights of legitimate medicine.

True to the Death.

THE death of a medical man at his post from causes connected with his professional work is so common as to be taken by the outside world quite as a matter of course. The latest martyrdom of this kind is that of Dr. Joseph Everett Dutton, a graduate of Liverpool University. Although only twenty-nine years of age, he had already taken part in three expeditions sent out by the Liverpool School of Tropical Medicine. On one of these he earned lasting fame by discovering the trypanosome parasite, thereby disclosing the cause of sleeping sickness, and conferring a lasting boon upon mankind. At the time of his death he was engaged with the expedition sent out in 1903 to investigate trypanosomiasis and tick fever. The expedition discovered the cause of tick fever, but unfortunately Dr. Dutton contracted the disease, which proved fatal. His name might well be added to the list of civilian heroes whose names are placed in the marble shrine founded for the purpose by the late Mr. G. F. Watts in the heart of London.

Lay Papers and Medical Treatment.

WE rarely have reason to congratulate our lay contemporaries on their success in dealing with matters of medical and surgical treatment, a subject which, by its very nature, is unsuited for discussion in the pages of journals for general reading. Unfortunately, however, recognising the curiosity undoubtedly felt on such matters by many of their readers, various journals think it necessary to publish from time to time articles dealing with some disease prominently before the public at the moment. Such articles are usually misleading, either on account of faulty information, or with the deliberate aim of producing a sensation. Unfortunately, even when the name of a medical man is attached, the article is not any the more trustworthy, for medical men who are competent to speak with authority are very properly chary of communicating their opinions through the medium of a public newspaper. Some weeks ago we commented on an article appearing in one of the leading monthly reviews, under the name of a medical practitioner, in which the doctrine was loudly preached that appendicitis was due to the use of saline aperients. Last week we noticed in an Irish daily, the only representative in Ireland of the halfpenny press, a disquisition by a Dublin practitioner on the cure of cancer. The article was an intemperate and ill-informed encomium of M. Doyen's work, and was calculated to lead the

public to believe that M. Doyen's treatment had been proved to be completely efficacious. The writer even stated that no deaths had occurred among patients under M. Doyen's treatment; the notorious lawsuit for return of fees by the widower of one lady patient should have been sufficient to guard against such an obvious misstatement. Reference was made, too, to the case of an Irish lady of title, whose name is given, who is stated to have been recently cured of cancer by M. Doyen. When one reflects that among the readers of the *Irish Independent* there must be many sufferers from this fearful disease, one cannot condemn too strongly the publication of jejune and sensational statements calculated to give rise to hopes which can never be fulfilled.

M. Doyen in London.

WE notice that the daily press is announcing that M. Doyen is proposing to take a house in London for the purpose of treating cancer patients, and that M. Doyen himself will be available for consultation by those whom he is unable to accommodate in his home. It is possible that the report, although it is given with a good deal of circumstantial detail, is a *canard*, and we certainly hope that it is. M. Doyen, as our readers know, has incurred a good deal of hostility in his own country by the methods he adopts, and if his treatment is all that he claims for it we feel sure that he should find his hands full in Paris. Financially there should be no reason why his French connection should not be sufficiently remunerative, without his coming to London. If English medical men were placed fully *au fait* with the details of the plan he lays down, and if this were shown to be of service in dealing with malignant growths, our profession would be only too thankful to use it in Great Britain. On the other hand, any man, medical or lay, who gives out that he has a new treatment for cancer is sure of a rush of patients, for a time at least, and whether successful or not, the author is not likely to raise himself in esteem if it be suspected that he exploits his method for his own advantage and not for that of humanity at large. In the paragraph containing the news of his advent it is stated that "it is understood that the fees charged will somewhat define the limit of M. Doyen's work, since, were treatment gratuitous, the demand upon his services would be a serious barrier to his work." If things are to be as here stated, we can only say the transaction has an ugly business-like look about it that is happily foreign to the practice of medicine, not only in this country, but throughout the civilised world. Another point is, whether under the special circumstances of the case the General Medical Council would recognise his claims to be registered in the United Kingdom. Without registration his practice would be irregular, if not illegal. Nor could he then engage any qualified English assistant, as that would constitute illegal "covering." It is to be hoped, how-

ever, that M. Doyen does not contemplate raising so undesirable a storm on this side of the Channel.

The Rontgen Congress.

THE first decade since the discovery of the rays was made known to the world is being celebrated this week in Berlin by a Congress, in which most of the leading medical and scientific men in Germany are taking part. The objects of the Congress are twofold: to survey the brilliant achievements rendered possible by Professor Röntgen's discovery, and to do public honour to the discoverer himself. The latter has persistently refused personal rewards, being satisfied as well as gratified by the knowledge that he has rendered some service to humanity. Orders and distinctions have, however, been showered on him, and, contrary to the usual custom, a public monument has been erected to him in Berlin while he is yet living. Professor Röntgen, it may be mentioned, was born in 1845. He studied physics at the University of Zurich under Professor Kundt, obtained his doctorate in 1868, and the following year accompanied his teacher to Wurzburg. After lecturing for a short period in Strassburg he was called to Giessen, where he occupied the chair of physics, and in 1888 became director of the Physical Institute at the University of Wurzburg, where he devoted himself to research work, which culminated in the discovery of the rays which bear his name. Munich University was the next preferment offered him, where, since 1899, he has been prosecuting his experimental studies in physics and chemistry.

Manslaughter by Motor.

THE coming of the "motor" marks a great stride in that part of the world's history which is recorded in the growth of rapid locomotion. Like all great mechanical appliances, it must unhappily exact a relentless toll of human life. It is the duty of the law, however, acting as the representative guardian of the subject, to see that the penalty is reduced to its minimum. Any death avoidable by reasonable foresight, skill, prudence and caution is unnecessary sacrifice of life. The motor is multiplying in the highways and byways of the land. It is becoming a constant source of danger to the life, limb and property of the nation. So far it has been chiefly the plaything of the rich, but it will soon become the necessity of the middle-classes and of men engaged in commercial and agricultural pursuits. The legislature has failed to recognise and meet the needs of the situation. Its speed limit of twenty miles, for instance, is far too high. The whole of the motor system in the United Kingdom could be brought under instant control were it made compulsory by law for each motor to have machinery so constructed as to be incapable of being driven at a speed over ten or twelve miles an hour. Any Government introducing this sensible piece of legislation would earn the gratitude of the whole nation.

Fingerprints of Crime.

OF late years the attention of the public has been forcibly drawn to the defectiveness of our police law administration. The series of miscarriages of justice that began with the Cass and culminated in the Beck cases has fixed itself, indelibly in the mind of the man in the street, who, after all, constitutes the ultimate court of appeal. In other words, sooner or later all defective social organisations must be reformed according to the lights of the average citizen. That is the inevitable outcome of representative government, even in a curtailed form. Anyway, criminal law reform is now a burning question. Our police methods demand instant inquiry and reform if they are to reinstate themselves in the confidence of the country. Almost the only scientific advance by the police of the United Kingdom for the past generation has been the adoption of a scientific system of identification. In former days the chief evidence of the kind was obtained from footprints, obviously a rough and untrustworthy plan. Nowadays, however, the print of a thumb or a finger furnishes absolutely sound and trustworthy circumstantial evidence. It is a matter of regret, however, that delicate scientific work of this kind is entrusted to police officers who have shown themselves to be untrustworthy where prosecutions are concerned. In the interests of the public work of this kind should be performed by men of medical education whose evidence would be not only technically accurate, but also absolutely above suspicion of professional bias.

Lincoln Typhoid Epidemic.

FRESH cases of enteric fever continue to be reported in Lincoln with a frequency that is far from confirming the confident report advanced some weeks ago that the original epidemic had ceased and that fresh attacks were merely of a secondary or local origin. Ten days ago the number of cases reached a total of 1,000 in the town itself, with a death-roll of 110; but, including neighbouring districts, the grand total of cases was 1,067. Lincoln is, indeed, paying a terrible penalty for her neglect. The city is shunned by racing men, theatrical and music-hall entertainers, cathedral visitors, commercial travellers, and even by tramps. The *Daily Mail* of April 24th published a detailed statement as to pollution of the Catchwater Drain, which flows through Skellingthorpe, a village three miles from Lincoln, and one of the sources of the Lincoln supply. It has long been known that the town water was derived from contaminated sources. In view of the seriousness of the position at Lincoln, we feel it a public duty once again to draw attention to the fact that a sterilising apparatus, used largely in France, can be applied to purify the town water supply. Nine weeks ago we told the authorities of Lincoln that in ten days they could have a "Salvator" apparatus at work, and be supplying the citizens with absolutely safe water. The

responsibility of disregarding that advice must rest with the Lincoln Town Council.

The Forthcoming Visit of English Medical Men to France.

IT is announced that complete reception arrangements have been made for the English medical men who are going over in May for a return visit to their professional colleagues. The English visitors will number about 152 persons, including twenty-six ladies. The latter will be met by a special ladies' committee. Members of the Reception Committee will meet their visitors on the evening of May 10th at the Gare du Nord. Later, the guests will attend the official reception at the Sorbonne. On May 11th the programme includes the Faculty of Medicine, the Public Assistance Department, and the Hotel de Ville. On Friday, May 12th, all will take the train for Chantilly, to visit the chateau and the museum, while in the evening there will be in Paris a musical, theatrical, and choregraphic soirée at the Automobile Club. On the Saturday there is to be a visit to the Pasteur Institute, and to the Hertford Hospital. In the evening there will be a final banquet at the Grand Hotel, the ladies of the party going to the Opéra to see the performance of Glück's "Armide."

The Pathological Chair at Cairo.

DR. A. R. FERGUSON, senior assistant to the Professor of Pathology in the University of Glasgow, has just been appointed Professor of Pathology in the Medical School of Cairo. Dr. Ferguson graduated M.D., with first-class honours, in 1902, receiving the Bellahouston Gold Medal for best thesis of the year. A large number of the younger medical men competed for this appointment, as the Medical School of Cairo is large, and supported by the Egyptian Government; it also offers large resources for research work. Dr. Ferguson, during the years he has been connected with the Glasgow University, Western Infirmary, and various medical societies, has acquired a considerable reputation in those subjects with which he has been specially connected, and he will take with him to his new sphere of labour the best wishes of the entire body of the students of the University and of the profession generally in Glasgow.

The Crinoline Scare Once More.

AFTER ten years' repose, the ancient crinoline bogey has undergone a journalistic resurrection. Mrs. John Strange Winter says our womankind are threatened with this fantastic invasion. She affirms it in a newspaper letter, the chief points of which appear to be: (1) The crinoline scare of twelve years ago is once again upon us; (2) twelve years ago she (J. S. W.) obtained 21,000 signatures from women pledging themselves against crinoline; (3) she now wants 121,000; (4) she is an extremely busy woman; (5) the threatened resurrection of crinoline is thus more due to men, not to women;

(6) The male motive (apparently) is to make money by the sale of the steel required for the hoops; (7) that hooped skirts are a retrogression; (8) that Mrs. John Strange Winter's name in private life is "Stannard." We trust that our summary is fair, and we wish the gifted authoress every success in her spirited crusade. From a medical point of view there could hardly be a more unsightly and unwholesome feminine gear than that of crinoline, unless, indeed, we may except high heels and tight corsets.

Two Russian Medical Students Killed.

THE amenities of professional life in Russia appear to be on the point of vanishing altogether in the turmoil of revolution. At Odessa a week ago, 144 medical practitioners met to discuss the preventive measures prescribed by the Government in face of the expected cholera visitation. By a majority of 124 votes to 20 they decided to withhold their services as a protest against the actions of the Government. Among the audience were a number of disguised police agents, the discovery of whom led to uproar. A telephone message brought up a regiment of Cossacks, whose gentle methods in dispersing the meeting ended in the serious injury of seven persons, and the death of two lady medical students. The lot of medical men in the United Kingdom does not altogether rest upon a bed of roses, but happily they are not called to protest against the vagaries and iniquities of a despotic monarchy.

PERSONAL.

SOME time ago it was arranged to erect a memorial to the late Dr. Archibald Brown, of Mount Florida, Glasgow. The subscribers met recently and decided to erect a granite obelisk in Cathcart Cemetery. The Committee that was formed to obtain funds received great help and encouragement from the people resident in the district where the deceased so long practised.

IT is stated that Major-General Sir Ronald Lane has been selected to succeed Major-General Schwäbe as Lieutenant-General and Secretary of Chelsea Hospital.

SIR FRANCIS BERTIE, British Ambassador in Paris, has accepted an invitation to be present at a banquet to be given on May 13th to the British medical men visiting Paris.

DR. ROBERT REID RENTOUL, of Liverpool, will deliver a lecture on "Degeneracy; its causes and prevention" (with special reference to the proposed sterilisation of certain degenerates), before the Leicester Medical Union, in the Town Hall, Leicester, on Thursday, the 11th inst.

MRS. GARRETT ANDERSON, M.D., has contributed £50 towards the restoration of the Museum of the Norfolk and Norwich Hospital. Dr. Robert Barnes started the fund with £500, and £100 was given by the children of the late Sir Frederick Bateman, M.D.

At the Spring graduation ceremony of Glasgow University on April 18th, the honorary degree of LL.D. was conferred upon Sir William Whitla, M.D., Professor of Materia Medica and Therapeutics in Queen's College, Belfast.

THE Ingleby Lectures before the University of

Birmingham for 1905 will be delivered on Thursdays May 4th and 11th, at 4 p.m., in the Medical Lecture Theatre of the University by Dr. James Kerr, Medical Officer (Education), London County Council. The subject selected is mentally-defective children.

IT affords us pleasure to announce that Dr. Heywood Smith, vice-president of the British Gynæcological Society has recovered from his recent severe illness and resumed the practice of his profession.

WE regret to say that the illness from which the famous pianist, M. Paderewski is suffering at New York, has been definitely recognised as epidemic cerebro-spinal meningitis.

By permission of Lord and Lady Battersea, a bazaar, in aid of the Metropolitan Hospital, will be held on May 9th and 10th, at Surrey House, Marble Arch.

THE annual meeting of the Chelsea Hospital for Women will be held on Thursday, May 18th, at 4 p.m., the Chairman, the Right Hon. the Lord Glenesk, presiding.

A BALI will be held on May 24th, in aid of the Clarence Memorial Wing at St. Mary's Hospital. Amongst the patronesses are the Princess of Wales, the Duchess of Fife, and Princess Henry of Battenberg.

THE Duke of Connaught will preside at a festival banquet in aid of the Great Northern Central Hospital, to be held on May 17th, at the Savoy Hotel, London.

THE Irish members of the medical profession will be well represented at the forthcoming visit to Paris. Amongst those who have accepted invitations are Sir J. W. Moore, Sir Charles Ball, Mr. Lentaigne, Drs. Parsons, Peacock, Day, A. J. Smith, and J. Craig.

THE colleagues, former pupils, and other friends of Professor Pozzi, of Paris, have arranged to present him with a medal in commemoration of his having presided over the seventh French Congress of Surgery, and of having been promoted to the rank of Commander of the Legion of Honour.

THE DUKE OF NORTHUMBERLAND will preside on Friday, May 11th, at the annual dinner of the Royal Sanitary Institute in the Prince's Restaurant. Applications for tickets should be made to Mr. F. White Wallis, 72, Margaret Street, London, W.

DR. ARTHUR LATHAM delivered an address at the annual meeting of the Hospital Saturday Fund last week, in which he said there are 40,000 persons suffering from consumption in London alone, and if other forms of tuberculosis were included the number would be not less than 80,000. A brief report of the address will be found in another column.

DR. P. H. PYE-SMITH has been re-elected as representative of the Royal College of Physicians of London on the Senate of the University of London.

ON the 26th ult., Princess Christian performed the ceremony of affixing a brass tablet to the memorial stone of a sanatorium for consumptives, which is being erected at All-tymynydd, Carmarthenshire, by the West Wales branch of the National Society for the Prevention of Tuberculosis.

AT the annual meeting of the Manchester and Salford Sanitary Association on April 28th, Sir Charles A. Cameron, Medical Officer of Health for Dublin, delivered an address on "Impure Air Above and Below Ground."

ON the 24th inst., Sir Douglas (President of the Royal College of Physicians of London) and Lady Powell will receive the guests at a conversazione to be held at the Natural History Museum, Kensington.

LORD ROBERTSON will preside at the dinner of the Edinburgh University Club, to be held on May 24th, at the Criterion Restaurant, London.

At the fifth International Psychological Congress opened at Rome last week, Professor Leonardo Bianchi, the new Minister of Public Instruction, a leading authority in Italy on psychological science, delivered the inaugural address, in which he reviewed the growth of psychology in Italy.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

EDINBURGH.

ANNUAL REPORT ON THE HEALTH OF THE CITY OF EDINBURGH.—Sir Henry Littlejohn has just issued his report for the year 1904. Every year some new feature is introduced into this report, and in this one the excellent plan is adopted of printing a summary of the statistics on the first page, which gives at a glance a bird's-eye view of the state of matters sanitary for the year that has just passed. The population of the town is 331,977, distributed with the density of 29.07 per acre. The birth-rate was 23.42 and the death-rate 15.04. Of the total deaths just about one in every four was under one year, or 125 per 1,000 births. The zymotic death-rate was 1.14 per 1,000. The birth-rate affords little reason for gratification. It has been steadily falling since 1871, when it was 34.89 per 1,000, and at present is lower than in any of the large towns in England and Scotland, except Bradford (22.). To compensate for this, the low annual death-rate constitutes a record in the annals of the town. Ten or fifteen years ago 17 per 1,000 was a good average, and in the sixties and seventies such figures as 23 or 27 per 1,000 were common. The age distribution of the deaths was much the same as in former years. On the whole, the city has been comparatively free from serious zymotic diseases, but whooping-cough and diphtheria have been somewhat more prevalent and attended with a greater mortality than in the previous year or two. One case of hydrophobia occurred, the patient having been bitten by a dog on board ship eight months before his fatal illness. He was not treated at the Pasteur Institute. Deaths from tubercle show a slight but definite decline. Deaths from cancer remain fairly stationary on the whole. During the past six years the number of cases was 2,255, of which 57 per cent. occurred in females. More than a third of all deaths from cancer occurred from cancer of the œsophagus, stomach, intestines, or rectum. Cancer of the liver accounted for 257 deaths; of the breast, 197; and of the face and neck, 236. Of the last two mentioned, females predominated in the former in the ratio of 195 to 2, males in the latter in the ratio of 186 to 50.

NOTIFICATIONS OF INFECTIOUS DISEASE.—These totalled 2,559 in 1904, a decrease from the preceding year. Scarlet fever was much less, but small-pox and diphtheria were more prevalent. The same peculiarity in the distribution of typhoid fever and diphtheria is noted as in former years; namely, that while the former is twice as frequent in the old town, the latter is very much more prevalent in the new town and suburbs. What the reason for this is it is difficult to say. The "logical conclusion to be drawn from it is," says Sir Henry, "that children up till ten years should reside in the old town, and afterwards migrate to the new." Only one outbreak of typhus occurred; it was limited to the half-dozen members of one family. The increased prevalence of diphtheria is the chief fact the sanitary authorities have to face. From 1894 to 1899 the monthly number of cases was consistently below the mean; for the last five years the exact opposite state of matters is found, and the percentage is going on increasing. The cause of this is not apparent. It is not connected with milk supply or obvious sanitary defects, and is most common in the best parts

of the town. An inquiry is now being held, of which the result is to be published next year. May it not be that a great part of this increase is due to bacteriological diagnosis being so largely employed. The idea is confirmed by the fact that the average case mortality is only a half of what it formerly was, and such an explanation would account for its greater prevalence among the better class of the community, where sore throats of trivial nature are attended to, and do not pass unnoticed as they are too apt to do among the poor. Be this as it may, Sir Henry Littlejohn's inquiry will be awaited with interest next year. The incidence of small-pox during the early part of the year, as was chronicled from time to time in this column, is noted. It is certainly a comment on the vigilance of the sanitary inspectors that practically half of the 137 cases were detected by them before they were seen by medical men. The mortality among the vaccinated was 6.2 per cent., unvaccinated 28.5. Among vaccinated persons 29 per cent. were modified, 56 per cent. ordinary, 10 per cent. severe, and 5 per cent. very severe attacks; among unvaccinated the figures read 9 per cent., 34 per cent., 38 per cent., and 19 per cent. respectively. The usual statement on workshops and bakehouses concludes the report, of the wealth of statistical information of which this summary gives a very inadequate idea.

GLASGOW.

BACTERIOLOGICAL DEPARTMENT FOR RENFREWSHIRE.—The Upper District Committee have decided, on the recommendation of Dr. A. Campbell Munro, Medical Officer of Health for the County, to provide the necessary requirements for the bacteriological diagnosis of disease. Dr. Munro pointed out that most of the large towns round about Glasgow, Paisley, Govan and Partick had already the means for this purpose, while the County of Lanark had a special Bacteriological Laboratory. In diseases like enteric fever, diphtheria, and consumption it was very imperative that the diagnosis should be corroborated by bacteriological examination. In cases where there was doubt the medical man received "outfits" in which they sent on portions of the blood, throat swabs, or sputum. These were examined by the Bacteriologist, and his decision returned by telegram, if so desired. The advantages of this system were many, and the process would prove economical, as cases that would otherwise be sent on to the infirmary would be detained till bacteriological proof had been obtained; on the provisional diagnosis proving wrong the expense of keeping that patient in the infirmary would be saved.

A CONSIDERATE JUDGE.—In the Sheriff Small-Debt Court, Glasgow, a case of interest to the medical profession was decided by Sheriff-Substitute Boyd a few days ago, where a medical man sued an employer for professional attendance on an employé. The Sheriff considerably and sensibly said, in giving his decision:—"It is a positive hardship to a doctor to be summarily called away from his practice without some provision being made for his remuneration, more particularly if the case be of a very serious character, where the doctor cannot very well, to be humane, stipulate conditions regarding payment before giving his services, or, in the absence of any guarantee as to such, decline to give them. The hard letter of the law, however, allows the doctor no redress against the employer, unless the latter has given his personal guarantee to be liable." The Sheriff, in the absence of such a guarantee, was unable to give judgment in favour of the medical man, but suggested to the lawyer representing the defender that a fee should be paid the doctor on account of the urgent necessity for his services being tendered without delay. The suggestion, thus proffered, was agreed to.

BELFAST.

THE NEW INFECTIOUS DISEASES HOSPITAL.—The Public Health Committee of the Corporation is in trouble again with a large section of the ratepayers. This time it is not for leaving undone those things that they ought to have done, but for doing those things that they ought not to have done. As noted in these

columns, they are building a large infectious diseases hospital at Purdysburn, three miles from the near side of the city, and about seven or eight from the districts where typhoid most abounds. The site was chosen against the practically unanimous opinion of the medical profession in Belfast, and the work is well advanced. It has lately transpired that in May last year arrangements were made to bring the sewage from the new hospital into the city boundary and discharge it into the main sewer of the Balmoral district. The inhabitants of this district are up in arms, and have memorialised the Local Government Board, pointing out that it is exceedingly objectionable to take the patients out of the city and then bring their excreta back through it, especially as the district into which it is proposed to bring the sewer is one in which there are several large schools with many hundred pupils. According to the memorialists the Public Health Committee has not complied with the provisions of the Public Health (Ireland) Act, 41 and 42 Victoria, cap. 52, sect. 35, which enacts that the sanitary authority shall give three months' notice before commencing new drainage works in any district, as no such notice was given in this case, the inhabitants of the district only discovering what was proposed to be done when the work was actually begun. The whole question of the disposal of such sewage is a most interesting and important one, and there will be no little interest in the reply of the Local Government Board to the memorial.

Correspondence.

A MEDICAL REFORM BILL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Members of the Dublin Division of the British Medical Association will not, I fancy, be much perturbed by the fact that the Medical Acts Amendment Bill drafted by the Association—referred to in your editorial note of April 19th—has been laid before them. It is possible, although I venture to assert extremely improbable, that this new project of law may be taken up by Government and discussed in Parliament, but that it should, in its present form and under present circumstances find a place on the statute book is unbelievable by anyone who has closely watched the progress of medical legislation during the past thirty-five years. Proposed legislation of the kind is at present looked upon as a trades union move by the doctors for selfish ends; and it would be necessary to bring the real facts home to the minds of the bulk of members of Parliament before the smallest chance for the acceptance of a drastic scheme of medical law reform could be created. A large and active section of the House of Commons, including anti-vivisectionists and anti-vaccinationists, and numbers who dislike the medical profession merely as the representative of science which they distrust or hate, would strenuously oppose any measure which promised to afford protection to the profession or to prevent persons not legally qualified from practising. The truth might be perhaps forced home to the public as well as the Legislature if a Royal Commission could be appointed to inquire into the whole subject of unqualified practice and quackery, including the manufacture and sale of quack medicines. The Commission would have power to call witnesses and examine them on oath. Such an inquiry would prove and make plain that stringent laws directed against quackery although they might do something to the advantage of the profession, would do a thousand times more for the stupid, ignorant, or too confiding masses whose sufferings and weaknesses now render them an easy prey to cynical knavery. It could be easily proved that quackery forms a potent factor in deterioration of the public health, and thus, from the sordid point of view is ultimately a source of profit rather than loss to the legitimate practitioner. There exist vast classes of invalids with ailments entirely manufactured or at least aggravated and rendered chronic by quackery. Of these the great majority gravitate sooner or later into the hands of qualified men, and thus much money which would not otherwise

be earned, is put into the pockets of the profession. If the complete unselfishness of the profession in seeking to put an end to the more glaring of the abuses which at present exist cannot be proved, it can at any rate be demonstrated that amendment of the law might be made to act for the benefit of the classes who have most claim upon the guardianship of the State. Everyone who knows anything about the history of modern medical legislation must, I am convinced, recognise that without the education on the question which members of Parliament almost entirely lack no House of Commons will listen with patience to a Medical Acts Amendment Bill; and I venture to prophesy that if the Bill of the British Medical Association be presented without the preliminary action which I suggest, it will not have the smallest chance of favourable consideration, albeit backed as it may be by the united voices of 20,000 practitioners.

I am, Sir, yours truly,

HENRY SEWILL.

Cavendish Square, April 19th, 1905.

RHEUMATISM AND PSORIASIS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your current issue there appears a very interesting paper on "Some Aspects of Rheumatism in Connection with Skin Affections." The writer incidentally refers to the probability that psoriasis may be of rheumatic origin. He cites a case which he classifies as seborrhœa, but which probably most physicians would look upon as ordinary psoriasis. Whether we call the condition psoriasis or not matters little, I think, so long as we are agreed that the rash is one and the same. As I have made a very extensive study of rheumatism as it occurs in childhood, I am able to endorse Dr. Walsh's views so far as children are concerned. For some time past I have maintained that most (if not all) cases of psoriasis met with in children are rheumatic in origin. In September, 1904, I contributed a paper to the *British Journal of Children's Diseases*. In the course of my remarks I there state that "in childhood at all events psoriasis scarcely ever occurs save in rheumatic subjects. Often in questioning the parents we find that one or other of them is rheumatic, and not infrequently there is a parental history of psoriasis obtainable. In further proof that psoriasis is a rheumatic manifestation we have found great benefit result from the administration of anti-rheumatic remedies."

I consider that this subject deserves to be carefully studied, not only by dermatologists, but more particularly by pædiatrists, who naturally see large numbers of rheumatic children. Practically every writer on the subject denies that psoriasis has any connection with rheumatism. This is evidently not the experience of Dr. Walsh; nor is it mine. I can remember an adult patient in particular who had tried many remedies for a recurrent and very diffuse psoriasis which yielded rapidly to anti-rheumatic treatment in the form of aspirin internally and a salicylic acid paste applied to the skin. If our contention is correct, then the nature of psoriasis becomes a simple matter, and its treatment is put upon a less empirical basis.

I am,

Sir, yours truly

JAMES BURNET.

Edinburgh, April 26th, 1905.

PAYING PATIENTS IN GUY'S.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your article on the paying patients in Guy's electrical department is well worthy of the attention of the medical profession. The situation resolves itself into open competition with qualified medical specialists in electrical treatment. It is, moreover, an illegal competition, as the money that founded and furnished the electrical department at Guy's Hospital was given by a generous public for the good of the poor. That such money should become a means of underselling medical men constitutes a grossly illegal diversion of trust funds. As a medical electrician, I

may say that only last week I consented to give a not over-wealthy peerness of the realm twelve electrical treatments for six guineas, the very sum fixed by Guy's Hospital. A short while since a titled lady died at Charing Cross hospital while undergoing electrical treatment. Does Charing Cross also rob outside medical men of patients by charging fees to the well-to-do? The Hon. Stephen Coleridge recently had the courage to face the hospitals and prevent an illegal diversion of hospital subscriptions to medical schools. He will earn the gratitude of the medical profession if he can prevent the equally illegal application of trust money to commercial purposes with a view of making money for medical charities.

I am, Sir, yours faithfully,
A WEST-END PHYSICIAN.

London, May 1st, 1905.

THE ASSOCIATION OF MEDICAL DIPLOMATES OF SCOTLAND.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—Permit me space to urge upon the readers of the MEDICAL PRESS AND CIRCULAR who hold the qualifications of the R.C.P. and S. Ed. and Faculty of Physicians and Surgeons of Glasgow, to join the above Association at once, so as to strengthen our hands in urging our Petition to the Royal College of Surgeons of Edinburgh to alter the title of "Licentiate" to that of "Member." We want all holding these diplomas to join. In this way we shall voice the wishes of the whole body of Licentiates. Let us make a great effort by united action, to bring about the desired result. The Association has done good work already; it has had one of its objects fulfilled, viz., the granting of a distinctive Academic Gown for the Licentiates of the Royal College of Surgeons of Edinburgh; this ought to encourage us. The Colleges, in my opinion, welcome our endeavours to improve our status and professional position, and they will, I feel sure, help us in any legitimate and reasonable effort we may put forth to bring about these objects.

This Society has advanced rapidly in numbers, and we want it to still go on progressing—hence this letter asking all concerned to join.

Dr. David Walsh, 18A, Hanover Street, W., our able hon. secretary, will be pleased to receive the names of intending members, and let me ask those who wish to join to do so without delay in order that the work of the Association may be pushed forward rapidly, and our petition presented as soon as possible.

I am, Sir, yours truly,
CLAUDE ST. AUBYN-FARRER.
(President).

Westbourne Park Road, London, W.
May 1st, 1905.

Laboratory Notes.

*** SPANISH BRANDY.

HAVING recently analysed and reported on some of the leading French brandies, we have in turn examined a sample of Jimenez and Lamothe's Spanish brandy less known in the British market than the French productions previously analysed by us. This brandy yielded the following results:—

Total solids (grammes per 100 c.c.)	1'
Ethers (parts per 1000 of absolute alcohol)	8'
Furfural (parts per 100,000 of absolute alcohol)	1'
Aldehydes (parts per 100,000 of absolute alcohol)	23.4
Volatile acidity (parts per 100,000)	31.7
	(as acetic acid).
Fixed acidity (parts per 100,000)	19.8
	(as tartaric acid).
Absolute alcohol (by vol. per cent.)	42.6

This brandy is guaranteed to be the product of distillation in pot-stills from the fermented juice of the grape alone, and the above results are consistent with its being so. By a very wise provision of the Spanish excise laws all alcohol distilled and imported into Spain must be distilled from fermented grape-

juice. In the case of the particular brandy in question we understand that Messrs. Jimenez and Lamothe have made arrangements for bottling on the spot in their distillery, and hence those who desire to be certain of getting a genuine grape-brandy will be safe in ordering this brandy. As regards flavour and aroma this brandy is quite satisfactory and we have pleasure in bringing it to the notice of our readers.

Whether the particular virtue of genuine brandy depends on the ether it contains or on some other unascertained constituent, there can be no doubt that for medical purposes only a pure grape-brandy duly matured should be employed.

IN the analysis of Messrs. Martell's One and Three Star Brandies, which appeared in our issue of March 29th last, owing to a clerical error the aldehydes appeared as 2.1. and 2.1 respectively, instead of 9.6 and 9.3.

Obituary.

JOHN JENKIN LLOYD, L.R.C.P. ED., L.S.A.
LONDON.

MR. J. JENKIN LLOYD died suddenly at his residence, Llanelly, in which neighbourhood he was one of the best known practitioners. The deceased gentleman was a native of Llanelly. He was educated at University College, London, and took the Diploma of L.R.C.P. Edin. in 1880. He appeared to be in good health up to within a few hours of his death.

THOMAS TROLLOPE, M.D., M.R.C.P. & S.
L.S.A.

HASTINGS has sustained a serious loss in the death of Dr. Thomas Trollope, who died somewhat suddenly at his residence, 9, Maze Hill. He was a Bachelor of Medicine in 1854, and M.D. in 1868 of the University of Cambridge. He became a member of the Royal College of Surgeons of England in 1856, and of the Royal College of Physicians in 1869. For many years he held the position of senior physician to the Hastings and East Sussex Hospital; and his kindly manner endeared him to all. His loss will be felt generally, and the poor especially will miss him.

EDWARD HENRY WARNER, M.D., M.B., Ed.

We regret to record the death of Dr. Edward Henry Warner, of Broadway Road, Bishopston, who died recently at his residence from pericarditis. The deceased gentleman, who was 48 years of age, until a few months ago practised at Lawrence Hill, where he was well known and respected. He previously held a post at the Fishponds Asylum, and also acted as medical officer for the Bristol Union. Deceased received his medical education in the Edinburgh University, where he graduated M.B. in 1883.

PROFESSOR VON BASCH.

THE death is announced of Professor von Basch, who as Physician-in-Ordinary to the Emperor Maximilian of Mexico, assisted that unfortunate monarch on the day of his execution.

ALBERT HENRY BAINES, M.R.C.S., L.R.C.P.

THE news of the death of Mr. Albert Henry Baines, of Southport, gave rise to deep regret among his many friends and former patients. Born in Leicester, he received his medical education at Guy's Hospital. He was the Gold Medallist of the Society of Apothecaries in Materia Medica and Pharmaceutical Chemistry in 1886, becoming M.R.C.S. Eng. in 1888, and L.R.C.P. Lond. in 1889. He was Assistant Medical Officer on the male side of Colney Hatch Asylum. He then took to private practice at Eltham, and afterwards in Southport, remaining there from 1879 until his death. He created for himself a large practice, and at the same time gained the esteem and respect of his professional colleagues, and enjoyed it undiminished to the end of his career. For many years he was an active member of the honorary medical staff of the

Southport Infirmary, and later Honorary Consulting Physician to that Institution. He was also Medical Officer to the Convalescent Home of the Manchester and Salford District Provident Society, and Medical Referee to various assurance societies.

SURG.-MAJOR GOUGH ASHTON, M.B., L.R.C.S. IRELAND.

SURGEON-MAJOR GOUGH ASHTON, M.B., late Army Medical Staff, died at Oxmantown Mall, Birr, recently. He entered the Army Medical Service as Assistant Surgeon, October 1st, 1862, became Surgeon March 1st, 1873; and Surgeon-Major April 28th, 1876, retiring February 12th, 1887. He was in the Afghan war of 1878-80, receiving the medal granted for that campaign.

ROBERT PATRICK CONNELL, L.R.C.P. & S., IRELAND.

WE regret to announce that, whilst attending a patient recently at the Bradkirk Small-pox Hospital, Mr. R. P. Connell contracted the disease in a malignant form, and was himself conveyed to the hospital on Good Friday. Here he was attended by his colleague, Dr. Sharples, but succumbed. The deceased, who was 37, was the son of Major Connell, of Southport, and had only been in practice at Bamber Bridge, near Preston, for two years. He was educated medically at Dublin, where he took the Diploma of the Irish College in 1891.

Medical News.

The Hospital Saturday Fund and Consumption.

THE Lord Mayor of London presided at the annual meeting of the Council of this Fund on Saturday last at the Mansion House. A statement of the work accomplished during 1904 was presented by Mr. A. S. Harvey, the chairman of the council, who said the year's collection had been "a record one." The net income was £24,344, compared with £23,694 in 1903. No fewer than 36,000 letters of recommendation had been issued. A site of 250 acres had been selected at Benenden in Kent, on which it had been decided to erect sanatoria to accommodate 200 patients suffering from tuberculosis. Dr. Arthur Latham, whose works on the subject are well known to our readers, delivered an address on the industrial classes and the treatment of tuberculosis, in which he said that in London alone nearly 8,000 individuals died each year from consumption, and another 8,000 probably succumbed to other forms of tuberculosis, many of them being in the prime of life. Further, many were slowly treading the path towards death; for every man who died there were five others who were certainly, though slowly, succumbing to the disease. In London to-day there were 40,000 persons suffering from consumption, and if all forms of tuberculosis were included the number was not less than 80,000. Calculating the population of the metropolis at five millions, these figures showed that out of every sixty-five people one at least would be dead in five years' time from tuberculosis—dead from a preventable disease, which owed its origin to filth. He said deliberately that they did not get full value for the money now spent, for the consumption hospitals were not properly organised for the immediate and economic relief of their patients. These hospitals had done a great work in the past, but they were not abreast of recent knowledge. Four reforms were, he contended, essential: (1) The establishment of a number of municipal or other institutions, where, on payment of a small fee, any working man or woman could be examined, early detection of the disease being of the first importance; (2) all hospitals to be brought into close connection with various organisations existing outside, this being done by the employment of almoners; (3) the discarding of the system of letters of recommendation, cases to be admitted on their merits, patients with advanced and hopeless disease to be refused admission, and dealt with by the Metropolitan

Asylums Board; (4) every consumption hospital to be in close touch with sanatoria in the country. This would increase the value of consumption hospitals tenfold.

Royal College of Physicians, London.

At the ordinary quarterly *comitia* of the College, held on Friday last, the president, Sir R. Douglas Powell, M.D., in the chair, the following members of the College were elected to the Fellowship:—Duncan Burgess, M.B. Camb., Sheffield; Thomas Watts Eden, M.D. Edin. Wilfred J. Harris, M.D. Camb.; Bedford Pierce, M.D. Lond., York; Leonard Rogers, M.D. Lond., Calcutta, India; J. W. Russell, M.D. Camb., Birmingham; J. H. Sequeira, M.D. Lond.; H. Batty Shaw, M.D. Lond.; E. Ivens Spriggs, M.D. Lond.; W. B. Warrington, M.D. Lond., Liverpool; A. Whitfield, M.D. Lond.; R. A. Young, M.D. Lond.

The following candidates having passed the required examinations were admitted members:—A. J. Jex-Blake, M.A., M.B. Oxf.; F. E. Taylor, M.A. Vict., M.B. Lond., L.R.C.P.; George W. Watson, M.D. Lond., L.R.C.P.; W. H. Wynn, M.D. Lond., L.R.C.P.

The Baly medal, instituted in 1866 by Dr. F. D. Dyster, of Tenby, in memoriam Gulielmi Baly, M.D., which is awarded every alternate year on the recommendation of the president and council to the person who shall be deemed to have distinguished himself in the science of physiology especially during the two years immediately preceding the award, was awarded to Professor Pawlow, of St. Petersburg, as having pre-eminently distinguished himself in the science of physiology.

On the recommendation of the committee of management, the Swansea General and Eye Hospital was added to the list of general hospitals, and the Willesden District Isolation Hospital to the list of fever hospitals recognised by the examining board in England.

The following candidates for the college licence, having conformed to the by-laws and regulations and passed the required examinations, had licences to practice physic granted to them at this meeting:—S. C. Allen, F. B. Ambler, B. N. Ash, I. G. Back, A. O. Bisson, E. Brabazon, R. C. Bright, Charles B. D. Butcher, H. C. Cameron, T. A. Chater, G. H. Cheyney, C. St. A. Coles, R. John H. Cox, S. E. Crawford, V. A. Crinks, C. H. Cross, A. S. Daly, D. M. Davies, W. L. Dickson, P. A. Dingle, C. J. S. Dismorr, J. S. C. Douglas, A. M. Dowdall, S. M. Dowling, T. W. N. Dunn, W. Edmundson, J. N. F. Fergusson, G. Finch, E. V. Frederick, K. F. Gordon, H. E. Graham, S. G. L. Graham, G. F. Hardy, W. D. Hartley, C. F. A. Hereford, W. H. Hey, G. Holroyd, E. C. Hood, A. W. Hooker, C. W. M. Hope, A. S. Hosford, J. B. Howell, T. M. Hughes, C. W. Hutt, R. R. Huxtable, C. E. Iles, J. R. Irwin, A. M. A. James, F. A. Juler, E. N. Jupp, F. W. Kemp, B. W. Lacey, L. Llewelyn, *F. J. Loveday, D. G. MacGill, F. S. Machin, T. W. Maddison, H. P. Martin, J. C. Mead, W. Miles, H. Mills, P. F. Minett, B. E. Moss, R. C. Neil, A. B. O'Brien, D. C. L. Orton, V. N. Ouranofski, P. R. Parkinson, P. L. Pearce, A. H. Pinder, R. E. Pitts, G. C. Pounds, G. Raymond, A. G. L. Reade, J. D. Reid, P. G. Reilly, F. M. P. Rice, D. H. Richards, R. L. Ridge, J. C. L. Roberts, H. H. Rolfe, G. F. Rudkin, J. E. Rutherford, E. Schwarz, H. E. Scoones, H. M. Scott, W. L. Scott, T. W. Sexton, C. A. Smallhorn, A. Smith, T. Sturdy, S. H. Sweet, A. B. Sykes, G. Thom, J. D. Thomas, L. C. Thompson, A. Toulmin, W. S. Tresawna, J. R. R. Trist, R. A. Veale, W. C. A. Ward, W. J. Weston, A. G. Whitaker, F. E. Whitehead, A. S. Williams, W. P. G. Williams, D. Wilson, E. D. Wolff.

North-East London Post-Graduate College.

THE opening lecture of the summer Session of the North-East London Post-Graduate College will be given by Dr. H. D. Rolleston, Physician to St. George's Hospital, on Thursday, May 11th, at 4.30 p.m., at the Tottenham Hospital, N., on "High Arterial Tension. Its Results and Prevention." The series of clinical lectures of which this is the first for the present Session, is free to all qualified medical practitioners.

Notices to Correspondents, Short Letters, &c.

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

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 re-forwarding 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.

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.

DR. FANNING.—Your paper is marked for early insertion.

THE RETORT COURTEOUS.

"Look at me," exclaimed the leading lawyer warmly: "I never took a drop of medicine in my life, and I'm as strong as any two of your patients put together."

"Well, that's nothing," retorted the physician, "I never went to law in my life, and I am as rich as any two dozen of your clients put together."—*Ez.*

MR. J. L. F.—We will accept your proposition to act as arbitrator in the dispute on condition that your opponent agrees.

MUSEUM SPECIMEN.

To Museum Curators, &c.—To be had cheap, a Prostate Gland of large size. The former proprietor has (he is pleased to say) no further use for it. He still retains his "appendix."

R.A.M.C.—The little work by Surgeon-Colonel Caldwell "On Diseases of Armies in the Field" and their treatment will, we think, fully satisfy your requirements. The Parkes's Memorial Prize was recently awarded to the author of this work.

THE UNDESIRABLE ALIEN.

A CORRESPONDENT referring to our leader last week on "The Aliens Bill" calls attention to a pamphlet on this subject from "The Medical Standpoint" recently issued by Dr. Rentoul of Liverpool, in which there are some interesting statistics regarding the number of undesirables who are refused admittance to countries like the United States, Canada, Australia, but who in this free country of ours quarter themselves without hindrance on the benevolent taxpayers, subsequently becoming inmates of our insane and criminal asylums, and distributors of every conceivable disease in its most loathsome forms.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MAY 3rd.

OBSTETRICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Dr. V. Benney, Mr. Foulerton, and others. Short Communications.—Dr. C. E. Purslow: Repeated Tubal Pregnancy; Abdominal Section on each occasion. Paper:—Dr. Boxall: Mortality in Childbed both in Hospital and General Practice.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus, E.C.).—6.30 p.m. Annual Meeting. 7 p.m. Annual Oration:—Dr. E. Humphreys: Excretion with special reference to Vicarious Excretion in Bright's Disease.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. H. L. Barnard: Clinique. (Surgical.) 5.15 p.m. Mr. J. Pardo: Cystoscopy and Urethroscopy.

CENTRAL LONDON THROAT AND EAR HOSPITAL (Gray's Inn Road, W.C.).—5 p.m. Demonstration: Mr. Nourse: Nasal and Aural Accessory Sinuses.

THURSDAY, MAY 4th.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—8 p.m. Card Specimens will be shown by Mr. J. J. Evans, Mr. G. W. Thompson, Mr. C. H. Walker, Mr. L. Paton, and Mr. W. I. Hancock. 8.30 p.m. Papers:—Dr. L. Buchanan. (1) Choroiditis; (2) Results of Birth Injury to the Cornea.—Dr. A. J. Ballantyne: Anterior Synechia of the Papillary Membrane.—Mr. S. J. Taylor: Notes on a Case of Pulsating Exophthalmos cured by Ligature of the Common Carotid.

NORTH-EAST LONDON CLINICAL SOCIETY (Tottenham Hospital, N.).—4 p.m. Papers:—Dr. J. W. Hunt: Personal Errors in Diagnosis and Treatment.—Dr. F. Tresilian: Certain Points in Diagnosis.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Dr. C. R. B. Kestley Diseases and Dislocations of Hip-Joint.

FRIDAY, MAY 5th.

WEST KENT MEDICO-CHIRURGICAL SOCIETY (Royal Kent Dispensary, Greenwich Road, S.E.).—8.45 p.m. Address:—The President: Corns and Bunions.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN (11 Chandos Street, W.).—6.30 p.m. Clinical Cases will be shown by Mr. S. Stephenson, Dr. F. J. Poynton, Mr. G. Pernet, and others.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Dr. H. Tilley: Clinique. (Throat.)

Vacancies.

Kent and Canterbury Hospital, Canterbury.—House Physician. Salary £90 per annum, with board and lodging. Applications to the Secretary.

Nottingham General Hospital.—Assistant House Physician. Salary £100 per annum, with board, lodging, and washing in the hospital. Applications to the Secretary.

East Sussex County Asylum, Hellingly.—Assistant Medical Officer and Pathologist. Salary £175 per annum, with board, lodging, washing, and attendance. Applications to the Medical Superintendent.

Hull Royal Infirmary.—House Physician. Salary £110 per annum, with board and furnished apartments. Applications to the Chairman of the House Committee.

County Asylum, Mickleover, Derby.—Junior Assistant Medical Officer. Salary £190 per annum, with furnished apartments, board washing and attendance. Applications to the Medical Superintendent.

Walsall and District Hospital, Walsall.—House Surgeon. Salary £100 per annum, with board, residence, and washing. Applications to Mr. Edward J. Brookes, chairman, Leicester Street.

Miller Hospital and Royal Kent Dispensary, Greenwich Road, S.E.—Junior Resident Medical Officer. Salary £80 per annum, with board, attendance, and washing. Applications to the Secretary.

Kent County Asylum, Chatham, near Canterbury.—Third Assistant Medical Officer. Salary £140 per annum, with board, quarters, attendance, and washing. Applications to the Medical Superintendent.

Appointments.

BRADFORD, A. M., M.D. BRUX., D.P.H. R.C.P.S. Edin., L.R.C.P. Lond., M.R.C.S., Physician to the Chichester General Infirmary.

BOND, FRANCIS THOMAS, M.D. Lond., M.R.C.S., F.R.S. Edin., Medical Officer of Health for the Tisbury Urban District Council.

CHATTERTON, EDGAR, M.R.C.S. Eng., L.R.C.P. Lond., Pathologist to the Western Ophthalmic Hospital, Marylebone Road, W.

HARNETT, CHARLES JOHN, M.D. Lond., M.R.C.S., L.H.C.P. Lond., Honorary Visiting Surgeon to the Royal Sea Bathing Hospital, Margate.

HEWLETT, FRANK, M.B. Durh., Physician to the St. Luke's Medical Mission.

MACCARTHY, W., M.B. B.Ch., B.A.O.R.U.I., Certifying Surgeon under the Factory and Workshop Act for Abbeyteale District of the county of Limerick.

Births.

FORSYTH.—On April 27th, at Crinnee House, Southend-on-Sea, the wife of Charles Forsyth, K.B., &c., of a son.

Marriages.

ARMSTRONG—KENT.—On April 26th, at All Soul's, Langham Place W., Walter Seymour Armstrong, M.B. L.R.C.P., M.R.C.S., son of the late Rev. William Armstrong, M.A., formerly incumbent of St. Mark's, Dalston, to Florence Hannah, widow of (the late Bertie Gordon Kent, of Malsmawr Hall, Montgomeryshire.

FERNIE—STACK.—On April 26th, at St. Patrick's Church, Dalkey, co. Dublin, Francis E. Fernie, son of Edward Fernie, M.D., of the Radfords, Stone, Staffs, to Charlotte Edith Stack, daughter of the late Rev. Thomas Stack, senior Fellow of Trinity College, Dublin.

GRIMSHAW—NAWOLE.—On April 27th, at All Saints', Merriott, Somersetshire, Captain Ewing Wrigley Grimshaw, Indian Army eldest son of the late Thomas Wrigley Grimshaw, M.D., C.B., late Registrar-General for Ireland, to Isabella Gerakide, only daughter of the late Major Henry Beresford Nangle, of the Indian Army.

Deaths.

BURNS.—On April 29th, at his residence, 1 St. John's Terrace, North Circular Road, Dublin, R. A. Colston Burns, M.D., T.C.D. (of acute pneumonia).

CROSSE.—On April 25th, at 2 Gondar Mansions, West Hamstead, Mary, widow of Thomas Henry Burton Crosse, M.R.C.S.E., in her 78th year.

FOWKE.—On April 28th, at Byfield, Northants, Emma, wife of F. W. Fowke, M.R.C.P. and M.R.C.S.E., &c., aged 60 years.

O'NEILL.—On April 28th, Alice, the dearly beloved wife of Dr. E. D. O'Neill, Medical Superintendent, Limerick Lunatic Asylum. R.I.P.

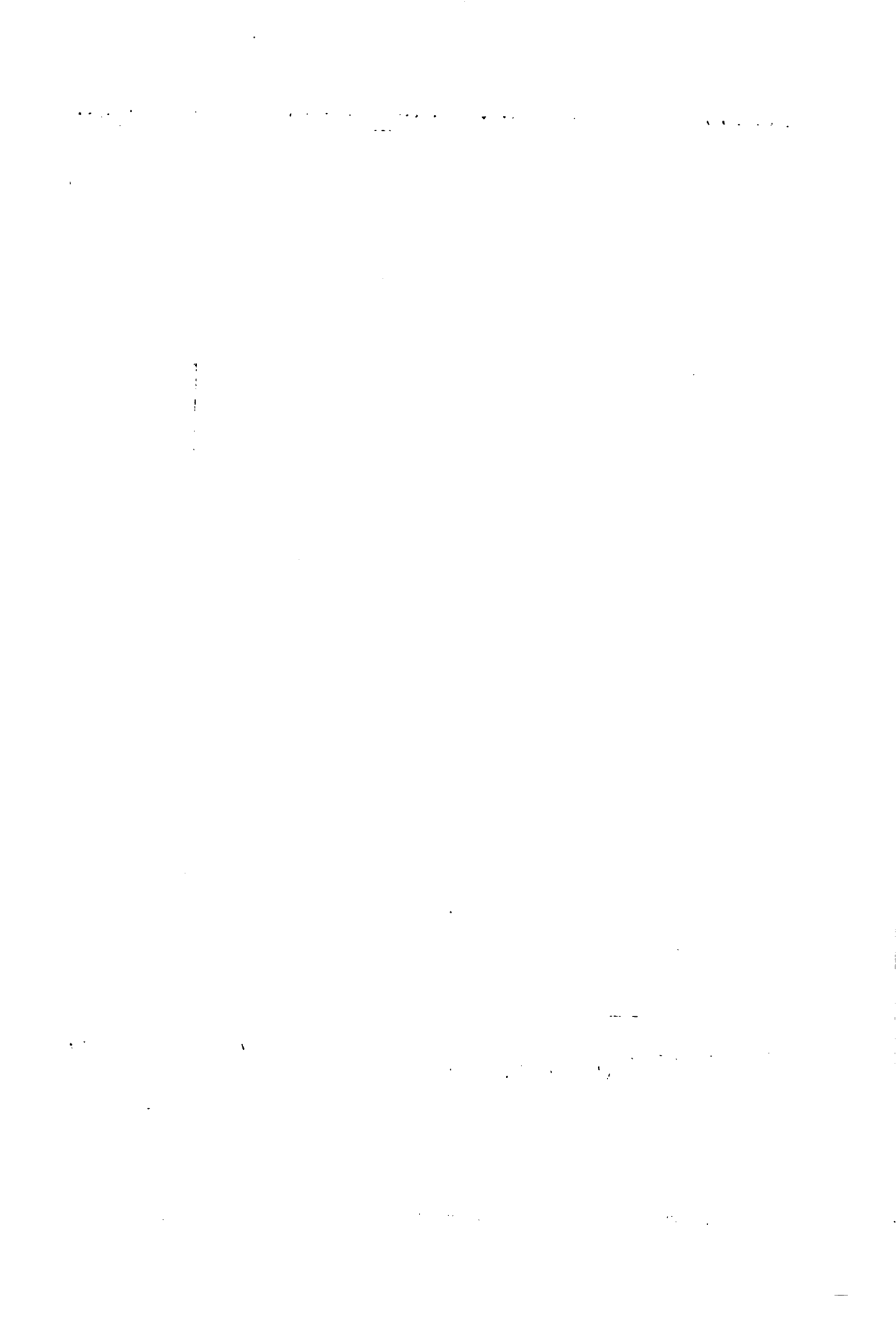




PLATE I.—*Skiagram of an obliquely contracted pelvis, due to synostosis of the left sacro-iliac joint.*
(From a skiagram by DR. W. S. HAUGHTON.)

[To illustrate Dr. Jellett's Paper on "Labour in a Unilateral Synostotic Pelvis."]

Original Communications.

NOTES ON A CASE OF LABOUR IN A UNILATERAL SYNSTOTIC PELVIS, (a)

By HENRY JELLETT, M.D., F.R.C.P.I.,
Gynæcologist and Obstetric Physician to Dr. Steevens' Hospital,
Dublin.

OBLIQUE contraction of the pelvis, and particularly that form known as Naegele's pelvis, is a rare condition in this country, and therefore I think that the notes of a case which recently came under my care may be of interest to the Academy. The nature of Naegele's pelvis is shown by the other name that is applied to this form of contraction, namely, the unilateral synstotic pelvis. Its characteristic and distinguishing feature is anchylosis of the sacrum with the ilium on one side, and almost complete atrophy of the lateral mass of the sacrum on the same side. The cause of the anchylosis is usually to be found in a congenital and unilateral failure of the centres of ossification from which the lateral part of the sacrum is normally developed. These changes cause a pronounced unilateral narrowing of the sacrum, and excessive pressure is, in consequence, thrown upon the deformed side. This pressure displaces the sacrum downwards and forwards on that side, and ultimately is responsible for the atrophy of the joint surfaces. In a few cases, it is probable that the sacrum in the first instance becomes displaced forwards on one side as a result of injury, and then becomes anchylosed in its new position, thus preventing further lateral development. In a few cases, inflammation of the sacro-iliac joint may be the cause of both displacement and synostosis. The result of these changes is a marked form of oblique distortion. The sacrum is depressed and displaced towards the diseased side, towards which it faces. The symphysis is drawn towards the healthy side. The inlet assumes the shape of an obliquely-placed ovoid, the long diameter of which corresponds with the oblique diameter drawn from the diseased joint. The true conjugate may be slightly increased in length, and the transverse diameters are shortened, both at the brim and at the outlet. Slight scoliosis is usually present in the lumbar region.

The patient, L. L., a primipara, æt. 24, was admitted to the Maternity ward of Dr. Steevens' Hospital on January 6th last. On examination, her abdomen was found to be unduly prominent, and the uterus, which was of large size, was so tense that the foetal parts could not be felt on palpation. As the condition of the abdomen suggested the possibility of the presence of pelvic contraction I examined her vaginally on the following morning. At that time she was not in labour, and the os was closed. A small head was

felt presenting at the brim, between which and the brim there did not appear to be any disproportion. I measured the oblique conjugate with my fingers, and estimated the true conjugate to be about or over 10 cms. Unfortunately I did not palpate the pelvic brim, and consequently I made no note recording the condition of the transverse diameter. A diagnosis of twins was made.

The patient came in labour the following day, and the membranes ruptured at 10.30 p.m. Labour pains continued during the night, and at 7 a.m. the following morning, my resident, Mr. Boyd, telephoned for me to come and see her on account of the delay in the expulsion of the foetus. I saw the patient at 8.30 a.m. The foetus lay in the second vertex position with the back behind, the head lay transversely in the pelvic cavity, Naegele's obliquity was well marked, and the anterior parietal bone presented. There was a large caput succedaneum. There was some difficulty in applying the forceps, chiefly owing to a transverse narrowing of the outlet, but when the blades were applied to the sides of the head, so that one lay in relation to the symphysis and the other in relation to the sacrum, they slipped on easily, and the head was delivered without difficulty. The child was alive and in good condition. On palpating the uterus a second foetus could be felt presenting by the head. I then waited for a couple of hours before rupturing the membranes of the second ovum, in order that the patient might obtain some rest, and finally ruptured the membranes at 11.30 a.m. As soon as I did so some meconium came away, and the cord and then a hand prolapsed through the os. I introduced my hand into the uterus with the object of turning and bring down a foot, but on doing so, I found that the retraction ring was nearly two inches above the symphysis, and the uterine wall was very tense, and that, in fact, version was too dangerous a procedure to attempt. As the head was presenting, and as there were no uterine contractions, and had not been any since the birth of the first child, I did nothing further, and the patient was returned to bed. During the foregoing manipulations, I recognised the existence of transverse narrowing of the brim. My reason for not delivering the patient immediately was, that in the absence of uterine contractions and in consequence of the partial emptying of the uterus, I did not think delay was likely to prove harmful, while immediate delivery was sure to be followed by uterine atony and possibly by post-partum hæmorrhage. At 1 p.m. I saw the patient again, and as her pulse had become more rapid, and her general condition was unimproved, I decided to deliver her, although there were still no contractions to speak of. On examination, the head presented at the brim, and the hand was prolapsed beside it. I applied forceps, pushed the head slightly upwards, so as to allow the replacement of the arm, and then applied traction. However, although a

(a) A paper read before the Obstetrical Section of the Royal Academy of Medicine in Ireland.

considerable amount of force was exerted, the head could not be induced even to enter the brim. As the child was dead, I accordingly perforated the head and extracted it. The perineal sutures which I had inserted after the birth of the first child were tied, and the patient returned to bed. At 5 p.m. I was again sent for in consequence of retention of the placenta. Both placenta were adherent, and there were and had been no uterine contractions, but as the patient's temperature had risen to close on 102° F., I thought that it was best not to wait any longer, and so removed the placenta manually. Very free hæmorrhage followed, and the uterus was plugged with iodoform gauze. The perineal sutures, which had been removed to facilitate the placental removal, were reinserted. The patient's pulse was then 116, and her temperature 102.1°. All the various operative procedures which I had been compelled to adopt were greatly hampered by the narrowing of the pelvic outlet, and consequently took longer than would have been otherwise the case.

The after-history of the case did not become satisfactory until the twentieth day, as, after delivery, her temperature gradually rose until, by the tenth day, it was 103° F. It then fluctuated between 99° F. and 102° F. for ten days more, when it gradually came down to normal. The cause of the temperature was an infection of the vaginal and perineal lacerations, and this infection at no time extended to the uterus.

On February 8th the patient, who was then completely recovered, was anaesthetised, with the object of making a diagnosis of the nature of the pelvic contraction. It was then found that the lumbar spine was deviated to the left side, that the promontory was badly marked and also deviated to the same side, and that there was obvious transverse narrowing and flattening of the brim on the left side. The pelvic measurements which were made then and subsequently are as follows:—

INTERNAL MEASUREMENTS.

Conjugate of brim 10 cms. (11 cms.)
Transverse of brim 10.5 " (13 ")

EXTERNAL MEASUREMENTS.

Greatest distance between
tuberities of ischium 8 cms. (11 cms.)
Conjugate of outlet 9 " (9.5 ")
Between anterior superior
spines 22 " (26.5 ")
Between iliac crests 24 " (28.29 ")
Between posterior superior
spines 5 " (9 ")
Between trochanters of
femora 29 " (31 ")

(The figures in brackets show the normal measurements.)

In addition to these measurements, others were made with the object of determining any disproportion in size between the left and the right side of the pelvis. These measurements are as follows:—

From left ischial tuberosity to right posterior superior spine, 17 cms. From right ischial tuberosity to left posterior superior spine, 19 cms.

From left anterior superior spine to spine of last lumbar vertebra, 16 cms. From right anterior superior spine to spine of last lumbar vertebra, 19 cms.

From left anterior superior spine to right posterior superior spine, 17 cms. From right anterior superior spine to left posterior superior spine, 20.5 cms.

From lower margin of symphysis to right posterior superior spine, 18.5 cms. From lower margin of symphysis to left posterior superior spine, 20 cms.

From left trochanter to right posterior superior spine, 19.5 cms. From right trochanter to left posterior superior spine, 21.5 cms.

The last five pairs of measurements are those originally suggested by Naegele for the identification of oblique distortion of the pelvis, and, as will be seen from them, the existence of oblique contraction in this case is very evident.

In order to still more clearly determine the exact nature of the deformity, my colleague, Dr. Haughton, very kindly took for me a skiagram of the case. The accompanying skiagram shows very clearly the condition of the pelvis, the deviation of the spinal column, the flattening of the pelvis on the left side, and the almost complete absence of the left lateral mass of the sacrum. I have submitted the skiagram and the measurements to Dr. Moorhead, who has lately devoted some time to the study of the anatomy of contracted pelvis, and to whom I am indebted for the initial description of Naegele's pelvis. He was at first inclined to adopt the opinion that the changes present might be due to scoliosis, and that being so the pelvis should be described as a scoliotic pelvis. Against this view, however, must be placed the entire absence of any evidence of rickets to which the scoliotic pelvis is practically always due. Subsequently, on comparing the skiagram and measurements with those of other specimens of Naegele's pelvis, he is, I think, satisfied that the case is one of unilateral synostosis.

The cause of the synostosis in this case is not obvious. As I have mentioned, the usually accepted causes are congenital failure of the centres of ossification, displacement of the sacrum to one side, or inflammatory or traumatic change in one sacro-iliac joint. In the present case, the patient states that she had never met with an injury, that she was unaware that she was in any way deformed, and that she never had any severe illness either during her childhood or in adult life. Accordingly, we are thrown for an explanation of the deformity upon either a congenital failure of the ossificatory centres or some unnoticed spinal deviation or injury during childhood. Dr. Moorhead considers that the evidence of the skiagram is against the former explanation, since the curvature of the innominate bone is sufficiently well marked to suggest that the synostosis must have taken place subsequent to a period of life during which the curvatures could have been developed by the pull of the sacro-iliac ligaments. In other words, if the synostosis had been congenital the innominate bone on the deformed side would be almost flat from before backwards. We must then, I think, in the absence of further information, attribute the deformity to the second explanation, the absence of the left lateral mass being explained by pressure absorption, and the synostosis being secondary to the displacement and not the cause of it.

Before concluding, I may draw attention to a curious condition of the urine that complicated the puerperium. The urine was examined by Dr. Rowlette, on admission of the patient, and was found to contain a fairly large quantity of albumen, and many granular casts. A fortnight after delivery it was again examined by Dr. Rowlette, and in addition to the albumen and casts it was found to contain very large numbers of short motile bacilli resembling the colon bacillus. These were

arranged in clumps resembling tube casts in form, so as to suggest that they had been thus moulded in the renal tubules. On further examination these clumps were found to consist of pure cultures of the colon bacillus. The patient was ordered salol in 10-grain doses every six hours, and subsequently urotropin in 5-grain doses. A week later the urine was again examined, and the bacilli were found still present in large numbers. Shortly after this the patient left the hospital, but continued to take the urotropin, and on examining the urine some three weeks later, all the bacilli had disappeared, but the albumen and tube casts persisted. I regret that the nature of the vaginal infection was not ascertained by bacteriological examination, as it would be of interest to know if it too was due to the colon bacillus.

THE OPERATION OF VAGINAL HYSTERECTOMY FOR MALIGNANT DISEASE OF THE UTERUS. (a)

By FREDERIC BOWREMAN JESSETT,
F.R.C.S.ENG.,

Surgeon to the Cancer Hospital, Brompton.

I HAVE operated altogether upon rather over 180 cases, which may be arranged in three classes, viz.: (1) Where the disease was limited to the external os; (2) where the disease commenced in the cervical canal and extended to the os or surrounding tissues; (3) where the disease was limited to the fundus of the uterus.

Of these 180 cases, 10 died from the result of the operation, but of the last 80 cases only one died. This is attributable to greater precision in operating, and more care in selecting cases. In my list of cases, 35 per cent. had recurrence, and died within one year; 23 per cent. had recurrence and died at periods varying from two to four years; 8 per cent. are alive and free from recurrence at periods varying from five to thirteen years; 8.3 per cent. had no recurrence at periods varying from two to five years; three cases were known to have died from other disease and had no recurrence; while the remaining 20 per cent. were lost sight of.

These figures, while not being very brilliant, nevertheless, I think, are sufficiently encouraging to warrant one in recommending patients suffering from this dire disease to undergo the operation. My experience leads me to the conclusion that the largest percentage of successes are obtained in those cases where the disease is limited to the os uteri. These cases, if seen and recognised in time, are, I think, most successful; indeed, in many of these cases I have had good success by supra-vaginal amputation, but although I practised this operation formerly, I now always advise the removal of the whole organ as it is impossible to say by the more conservative treatment if you have got beyond the limits of the disease, and in skilled hands the operation of total extirpation is very little more dangerous to life.

The next most favourable results are obtained when the disease is limited to the fundus of the uterus. These cases, if they are recognised early, are, I am sure, most successful, but the difficulty here arises of diagnosis, and my opinion is that if you see a woman who has had repeated and

excessive hæmorrhage, and on dilating the os the endometrium is discovered to be thickened and in places irregular, it is far better to remove that uterus than to curette it, with the almost certainty that the hæmorrhage will recur and after a while you discover when too late that you have to deal with a malignant condition of the fundus. If the endometrium is examined microscopically and the pathologist assures you it is malignant so much the better, but how often do we find the report favourable when later on malignancy declares itself. This is not due to any fault of the pathologist but from the fact that the portion removed was merely the healthy mucous membrane, while the diseased portion, even if it has been reached, is not the part which the pathologist received for examination.

Many of these cases, no doubt, may be classed as adenomyoma of the uterus, so well described by the President, as adeno-hæmorrhagia in the paper he read at the Society last December, and also described in a paper written by Dr. J. Murdoch Cameron and Mr. Archibald Leitch. It will be interesting in the future if special attention can be paid by surgeons and pathologists to this condition as it may be found that this really is a pre-cancerous stage of malignant disease of the body of the uterus. The most unfavourable condition for the patient is when the disease has commenced in the cervical canal and spread downward to the os; this condition is rarely recognised until the os is involved; in the meanwhile the disease has been spreading laterally into the tissues around, and the glands become early affected. In such cases my experience would lead me to expect early recurrence, and it is doubtful if it is worth while operating at all.

The question as to what is the best form of operation to perform is an all-important one. There would appear to be three forms of operation recognised by different schools of gynecology, viz., supra-vaginal amputation, by which I mean an operation by means of which one is able to practically dissect out the whole of the endometrium as well as to remove the os and cervix; (2) vaginal hysterectomy; (3) removal of the uterus by the abdominal route.

The first of these operations was very strongly favoured by Sir John Williams some years ago. I myself read a paper on this subject in which I related several cases of early carcinoma of the os where I performed this operation with marked success. It can, however, only be of use in very early cases of cancer of the os. I have not performed this operation now for some years, as I found the risk to the patient was nearly if not quite as great as total extirpation of the whole organ; and the difficulty of being sure of getting beyond the disease was not inconsiderable.

Another objection to it in patients prior to the menopause is that stenosis of the cervical canal is very likely to occur, which is the cause of very considerable distress and pain to the patient in after life. The selection of operations thus narrows itself down to the choice between vaginal and the abdominal route. Personally I prefer the vaginal route as there is very little shock to the patient after the operation and the surgeon is able to examine the adnexa quite as well by this route as he can by the abdominal, if not rather better. The chief argument for adopting the abdominal route appears to be that the uterus and tissues around can be removed more extensively, and the

(a) Read before the British Gynecological Society, April 13th, 1905. For proceedings see page 479.

sacral or lumbar glands can be removed if found to be enlarged. My experience would lead me to say if these glands are affected the patient is pretty sure to have early recurrence whichever route is adopted.

Finally, I would say that one great object we should endeavour to attain and to instil into the general practitioners—for these are the gentlemen who are consulted by patients in the first place—is early diagnosis. It is only by this means that any great amount of success is to be expected in relieving patients from this terrible disease. If the uterus is at all fixed or the broad ligament thickened, it is worse than useless to attempt any operation, as patients often suffer far more from recurrence than they would have done if the disease had been allowed to run its course.

Our great watchword, then, must be *early diagnosis*, and in cases where there is any doubt I would remove the uterus; better do so, than leave it until the disease has become so pronounced that it is *too late*.

MÉNIÈRE'S COMPLEX OF SYMPTOMS:

WITH A CRITICISM ON QUINCKE'S LUMBAR PUNCTURE TREATMENT AND AN ACCOUNT OF THE FIRST RECORDED CASE TREATED SUCCESSFULLY BY HYPNOTIC SUGGESTION.

By T. WILSON PARRY, M.A., M.D.CANTAB.

PART II.

Lumbar puncture is another method of treatment that has been recommended and tried for this disease of nerve-irritation. In a case attached to this paper I have added some remarks on the principles that underlie this method of treatment. I will, therefore, leave the case and its remarks to stand for themselves.

I have pleasure in being able to place before you a case of Ménière's Disease (Class II.) the new treatment of which—*viz.*, hypnotic suggestion, has been eminently satisfactory. So far as I am aware, it is the first case in London treated in this way; and even in Paris, the home of hypnotism, one has not read of any cases that have been treated by this new method. The honour of recommending this treatment and carrying the case to a most successful issue is entirely due to Dr. A. Ernest Jones, of University College Hospital. It has been my privilege to witness the treatment of this case from the outset. The brilliant result, as will be seen from the full notes adjoined to this article, far exceeded our most sanguine expectations. The picture of the cure of a man of some forty-four years, who had become prematurely old from the constant worrying and depressing effects of an eight years' unbearable tinnitus, vertigo and vomiting is vivid enough without further comment.

A Case of Meniere's Disease (Class I., Division B) treated by Lumbar Puncture, with remarks on the case and on this method of treatment.

CASE I.—The patient was a foreman at some wine stores, *æt.* 56, and was in a good state of health, no organic disease being discoverable anywhere. The urine, too, was quite normal. He had had rheumatic fever twice, but there were no endocardial changes to show this. He tells me that he "has drunk a lot in his time, but not for a man in his line." His principal drink was whisky and claret, but this has never been taken to excess he affirms. There is no history ascertainable of syphilis, epilepsy, or insanity.

His father is still living and seventy-eight years of age. His mother died at forty-four "having caught cold during the change of life." He has had nine sisters and one brother. The brother died in infancy, as did twin sisters. Two of the remaining sisters are married; one, aged fifty-eight, has five children all healthy and the other, aged fifty, has had three children, one of whom is said to have died from pneumonia. The five single sisters are all living and in good health.

Our patient had never felt properly well since having influenza in 1901, and he had since then a slight ringing and deafness in both ears. One day in April, 1904, he was walking down the street opposite Guy's Hospital when he suddenly noticed that the houses in the street seemed to be rocking. His first feeling on seeing this was that he could not walk any further and must fall. By a coincidence a friend was passing at the time, and seeing him in distress armed him into the hospital. The attack lasted about four hours. He did not vomit, nor did he even feel sick on that occasion. The slight deafness that he had hitherto had in the right ear was very noticeably increased during and after this attack.

His second attack occurred about a fortnight after this. He began this time by feeling sick. He went up to bed and, to quote his own words, "had the worst attack of any I have ever experienced. I retched and vomited and felt dreadfully giddy, with terrible pains in my head. All the things in the room seemed to be going anyhow, the gas seemed to be dodging about in all directions." This was at 8 in the evening, and it lasted for four or five hours. He went to business the next morning, however. Three weeks after this, the third severe attack occurred at about the same time in the evening, and it was similar, in every way but severity, to the second attack. Incessant ringing in the ear, vomiting with deafness and pains in the head of a "raking" character were the foremost and persistent symptoms.

On Sept. 15th, 1904, he was first seen at the Central London Throat, Nose and Ear Hospital by Dr. Dundas Grant, who put him on a mixture containing half a grain of quin. sulph. and m xv. acid hydrobrom dil ter die.

Examination of the ears exhibited the following:—

	R.	L.	
Galton's Whistle ..	3.6	4.6	} T. F.
Meatus ..	-13	-5	
Mastoid ..	-4	+	
Vertex ..	..	+
Rinne ..	..	+

Discharge ..	..	none
Vertigo ..	..	yes
Headache ..	..	occasional
Duration ..	..	5 months
Onset ..	..	gradual

Sept. 22nd.—Giddiness just the same.

24th.—Lumbar puncture was performed.

Ten cubic centimetres of cerebro-spinal fluid were drawn off between the last lumbar and first sacral vertebrae. The fluid was carefully tested both chemically and microscopically. It was found to be perfectly normal and no leucocytes were present. After this he felt better for nearly a week. All the symptoms were temporarily ameliorated. The deafness and tinnitus were better and the vertigo vanished entirely for five days. The vomiting also disappeared and this did not return.

29th.—Was still feeling better.

On September 30th, had a bad attack of tinnitus and vertigo. He was at work in the office when it came on. He got up when his chief entered and made an effort to walk with him round the cellars, but he staggered and had to put his hand on the wall to steady himself. He felt absolutely unable to proceed, as he knew he would have to stoop at certain places, and this he felt to be impossible under the circumstances. This attack lasted between five and six hours.

On Oct. 7th, had an attack which lasted about six hours. In this attack the tinnitus was first increased, and about an hour afterwards the vertigo appeared. It started about nine in the morning and lasted till about three. He was not sick nor did he feel nauseated. Bowels well open. At present he has a little dizziness, but this does not prevent him from getting about. When the attacks are on he cannot walk straight. The tinnitus seems to be increased first, then comes the vertigo and with it he notices increase in his deafness. The tinnitus is of a "hissing" character. On Oct. 11th there was another attack similar to that on the 7th, lasting about three hours.

On Oct. 12th he had the suspicion of an attack coming

on, but it passed off. He is not at all apprehensive of attacks coming on. Has had no sickness since the "lumbar puncture" was performed.

20th.—Has felt a little giddy every day during the past week. It is worse if he is in a close atmosphere. Had an attack (about three hours) of the nature that he felt he couldn't walk straight. It wasn't bad enough to cause him to fall. There was no sickness. Tinnitus still continues but is not constant. Before an attack of vertigo comes on, the tinnitus grows louder and "sounds like a bell for fully a minute." Cannot hear a watch on right ear or on right mastoid (the affected side). Can just hear it when placed on the left ear, but not on left mastoid process. Cannot hear watch placed on vertex. Has had a nasal catarrh the last fortnight. A "C" tuning fork placed on vertex, with both ears closed, is heard in right ear. Can hear a "C" tuning fork on right mastoid process and against right auricle, but not so well on his left ear. The quinine and hydrobromic acid still continued.

Dec. 8th.—I had a letter from him to-day to say:—"I am very pleased to say I am much better and have scarcely anything the matter with my head now. I have had a slight deafness followed by giddiness on three occasions since I saw you, but nothing to speak of. It has not lasted for more than half-an-hour each time and the last time I felt anything was about three weeks ago. I have had no sickness with the above attacks. I should have been at the Hospital on Oct. 27th, but was prevented by bad cold in my head and had to stay indoors for three days. After the cold I felt much better, it seemed to have cleared my head, and my hearing is now pretty good, both ears alike." He finishes up his letter by saying that "As I felt so well, I thought I ought not to give any more trouble, and it is likewise very awkward for me to be away from my work, even for one afternoon in the week."

Remarks.—It is difficult to say, in this instance, what part "Lumbar Puncture" played in the gradual cessation of Ménière's Symptoms. One point, however, stands out clearly and that is that whereas the patient had violent attacks of retching and vomiting before the "puncture" he never had this symptom after it had taken place. Quinine and hydrobromic acid, it must be remembered, were given regularly during the six weeks he was under treatment. We may now inquire why "lumbar puncture" should be performed for a case like this of Ménière's Syndrome.

In the first place we may say it is to reduce supposed intra-labyrinthine tension. I say "supposed," because it is by no means an easy thing to distinguish irritation of the ampullar branches of the auditory nerve by an increased amount of peri- or endo-lymph due to mechanical pressure from increased secretion, from that produced by other irritations. In a clear case in which we feel justified in diagnosing with certainty that the complex of symptoms is due to hæmorrhage or to a rapid exudation into the labyrinth, lumbar puncture, if to be done at any time, is then reasonably called for. In a case, however, which does not exhibit mechanical pressure symptoms it would be more reasonable to suppose that no good could result from treatment of this nature. I am of opinion that the case before us was hardly the right one to expect much from such treatment, as it was not an acute case, the onset of symptoms being gradual. How does lumbar puncture, we may ask, produce a reduced intra-labyrinthine pressure? The answer to this is purely anatomical. Gruber (a) has taken much pains in working out the physiology and anatomy of this point, and the results he has arrived at are briefly summed up as follows. The peri-lymph and the endo-lymph (both of which are of the nature of cerebro-spinal fluid) have each a safety-valve exit, in the case of intra-labyrinthine tension, whether urgent or otherwise. On the one hand the cerebro-spinal fluid in the peri-lymphatic space of the labyrinth can find its way into the sub-arachnoid space joining the cerebro-spinal fluid there. This is brought

about by means of the aquæductus cochleæ which communicates with the peri-lymphatic space of the labyrinth on the one side and the sub-arachnoid space on the other. Again, the endo-lymph in the utricle, saccule and semi-circular canals can find its way into the cranial cavity by means of the ductus endo-lymphaticus, a membranous tube which enters the ductus vestibuli of the pars petrosa and, passing through it, communicates with a cul-de-sac called the recessus cotugnii or saccus endo-lymphaticus, which lies between two layers of dura mater resting on a slight depression on the inner surface of the petrous portion of the temporal bone. An unlimited amount of peri-lymph can thus find its way into the cranial cavity, but only a small quantity of endo-lymph into the recessus cotugnii which is said to vary in size from a scarcely recognisable pouch to one as large as a small hazel nut. This arrangement is therefore a purely mechanical one, and it may be justly assumed, if cerebro-spinal fluid be subtracted from the cranial cavity, that in the peri-lymphatic space will instantly endeavour to supply its place in the cranial cavity and thus relieve the augmented pressure in the labyrinth.

It will be noticed I mentioned above that I thought either in apoplectic or acute exudative labyrinthine disturbance it is justifiable to use lumbar puncture, if this be ever justifiable. Now I personally believe that this method is not of much practical use in the treatment of Ménière's Disease or Syndrome; for if but a small amount of cerebro-spinal fluid be drawn off not much result can be expected, as it is well-known that this fluid is replaced with great rapidity. On the other hand if too large a quantity be deducted there is a grave risk of convulsions occurring which may be followed by the most serious results. Moreover, even in these days of antiseptic or aseptic surgery, there is yet no inconsiderable risk of setting up inflammatory disturbances at the punctured point which may lead even to fatal results, as the cerebro-spinal fluid is a culture-medium of the highest activity. Summing up then, I have no hesitation in stating that I think the principle on which this treatment is founded is not sound enough to justify its adoption as an alleviating measure even in true Ménière's disease; much more then do I think it unnecessary and even unjustifiable in those cases exhibiting well-marked Ménière's Syndrome from irritative ampullar causes, which are not the outcome of intra-labyrinthine mechanical pressure.

A Case of Ménière's Disease (Class I., Division B), treated successfully by Hypnotic Suggestion.

CASE II.—The patient was a solicitor's clerk, æt. 44, and first came under my notice on September 8th, 1904. Up to eight years ago his hearing was perfect and his health excellent. The family history does not help us much. His father, who was a first-class petty officer in H.M. Navy, died some twenty years ago. The patient tells me that his father used to have "attacks," though of what nature he could not say. He was fifty-five when he died, and, according to the patient, it was of "some affection of the heart and nerves." There appears to be no history of insanity. His mother died at thirty-three, after child-birth. He had one brother "who lived a fast life and died of drink and bad habits," and a second who died in infancy. This was all the family.

It was as far back as June 1892 when he first noticed he was becoming slightly deaf in his left ear. His right ear was quite free. This has gradually and steadily increased since that time. He thinks it was about the same time that a "buzzing" began in the same ear, and this, too, has been continuous since then.

His first attack occurred in November 1896. He was walking in the Strand when, without any apparent cause, he was suddenly seized with giddiness and vomiting. He reeled and was obliged to catch hold of some railings to prevent himself from falling. The attack lasted about a quarter of an hour. He went back to his office and finished his work. His hearing did not appear to be affected by this attack, nor did the tinnitus seem to be noticeably increased.

(a) "On Deafness, Giddiness, and Noises in the Head." By E. Woakes, M.D. P. 5.

His second attack took place in the Spring of 1897. It came on during a railway journey. When he reached Stratford Station he vomited on the platform, and felt so giddy that he was conscious of reeling as he walked. He had only about five minutes' walk to the house to which he was going, but was obliged to cling to the railings for support all along the route. On reaching the house he was going to, he again vomited, and crept on to a sofa where he lay for three hours. He left three and a half hours after his arrival, when the sickness had ceased, but the giddiness still continued.

When questioned as to what things he thought tended to induce or ward off an attack he told me that he thought travelling in a train, sitting with his back to the engine, was likely to bring on an attack. Being in a crowd certainly affected him unfavourably. Noises (especially street-organs) were distressing to him, and conducive to an attack. Strong light (electric, incandescent, or ordinary sunshine) in no way affected him; while, on the contrary, heat—especially sun-heat—did so. He has always felt better in winter than in summer. Stimulants in moderation did not seem to affect him. On the other hand he has specially noticed that some of his severest attacks have occurred when he has had no alcohol at all for a month or more. Liquid diet makes him worse; dry diet suits him best. Blowing his nose will produce temporary giddiness, or if he looks up suddenly.

On Examination.—Although the patient is only 44, he looks more like 60. His face wears an anxious expression. He is quite bald on the top of his head and tells me he has lost his hair during the time he has been afflicted. His memory is excellent. The constant symptoms he has been suffering from during the past years, he tells me, have much depressed him, and he is willing to undergo any treatment to give him even partial relief. No organic disease is discoverable, either generally, or locally in the throat, nose or ear. His urine is normal. A watch pressed against the left ear can only just be heard. If not touching the ear it cannot be heard. His Eustachian tubes are patent. The tympanic membrane appears quite normal.

On Sept. 8th, 1904.—Dr. A. Ernest Jones, under whose care he was at the Farringdon Dispensary, placed him on a simple mixture of bismuth carb., grs. xx. and pot. brom., grs. x., three times a day before food.

15th.—Felt better. Felt the medicine had done him good. Had had no sickness or giddiness that day, although he had had it every other day during the past week. Certainly looks better.

22nd.—Felt better. There had been no giddy attack during the past week. Medicine continued.

29th.—Had not been so well. Giddiness and vomiting had recurred. Had felt sick all day, but only vomited once. Did not feel able to do his work. Did not feel able to make appointments in case of an attack occurring before or at the time. Has lost a stone in weight during the past three months. (Normal weight about 10 stone.) Looks paler to-day. Tinnitus very bad to-day and "giddiness occurred on and off all day yesterday." Has rested ten consecutive Saturdays to Mondays in bed to see if rest would do him any good. Dr. Jones suggested treatment by hypnosis, which he said he would be willing to try. Dr. Jones then shone a reflected light by means of an ophthalmoscopic mirror from an electric throat lamp into his right eye, and was speedily able to throw him into a drowsy condition. When in this state Dr. Jones made the suggestions that the giddiness and sickness would disappear. The patient was particularly susceptible to hypnotic influences. I timed the experiment and found it only took one and a half minutes to place the patient in a cataleptic state.

Oct. 7th.—Has not felt giddy at all during the past week, nor has he vomited. Has only occasionally felt a little sick. The singing in the ear, too, has been less. Has taken no medicine during the past week. This was purposely not prescribed so that the negative or positive result of the experiment might be justly

considered. It only took three-quarters of a minute to place him in a cataleptic state. The impression that giddiness and vomiting should cease was again imprinted upon him when in the sub-conscious state. He told me that his walking, which was usually affected, had been decidedly better this past week. He feels firmer on his legs.

20th.—No sickness or giddiness at all since he was last here a fortnight ago. Last Sunday (the first Sunday he has been out for thirteen weeks) he went to see some friends for a few hours and was not at all affected by this. No drugs have been given. Although this damp and muggy weather does not suit him in the ordinary way and accelerates the giddiness and depression from constant tinnitus, he has felt better altogether. Has been able to attend to his work in a light way, either in the morning or in the afternoon, but not in both. Has taken his food much better and enjoyed it. Going out into the streets does not affect him as before. There is still singing and deafness in the left ear. Cannot hear watch when placed against left ear or on left mastoid process. Can hear watch over two feet away from right ear. When watch is placed on vertex can hear it, and when both ears are closed, he hears it in right ear. Is still very frightened of street-organs. Was not hypnotised to-day.

27th.—To use his own words—"Have been very, very fair. This is the fourth week I have had no giddiness nor sickness, and I have been able to do morning work regularly, or if I have to be busy in the afternoon, I take it rather easy in the morning. Being a little damp and foggy my singing in the ear is a trifle worse." His deafness is the same. Cannot hear what one says if the good ear is closed. Looks from ten to fifteen years younger. Can now move his head up or down or from side to side without any vertigo.

The rest of the story may be summed up in a few words. On Nov. 9, 15, and 26, also Dec. 1 and 14, I either saw him or had word from him to say that there had been no return of the giddiness or sickness. On Dec. 1st he was hypnotised. The former suggestions were strengthened and a new suggestion was made—viz., that the tinnitus should be no longer heard. On Dec. 14th I had word to say, "I am still keeping very well, no attacks of sickness or giddiness. The 'hissing' in the left ear is a little better, and does not make me feel so heavy and dull as formerly." On Jan. 4th, 1905, he practically sent the same account and to this date (April 25) he has been perfectly free from the vertigo and vomiting that were so persistent during the last eight years, while the tinnitus which he has is bearable and in no way interferes with his carrying on his work as a lawyer's clerk.

Clinical Records.

A SPORADIC OUTBREAK OF CEREBRO-SPINAL MENINGITIS.

By J. J. FANNING, L.R.C.P. Ed., &c.,
Medical Officer, Birr and Killyon District.

ON June 1st, 1902, I was called to F. G., a child, æt. 4, who had been ill for ten days previously. On examination I found the patient suffering from bronchopneumonia, temp., 102.5, pulse 116, and respiration 55. I saw the patient every day for the next four or five days, and there seemed in her case to be nothing out of the usual run of such-like cases. On the eighteenth day of her ailment meningeal symptoms began to develop. There was strabismus with hyperæsthesia of a very pronounced character, and a well-marked tache and retraction of the abdomen. Kernig's sign was also present. The child lay curled up in the usual decubitus of meningitis. As the patient was robust a leech was applied to each temple, and it was noticed that the skin at the site of the leech bites became gangrenous in a short time after. The case during the nineteenth and twentieth days presented the appearance of an ordinary meningitis. On the twenty-first day of the patient's illness I was asked to see her sister, who was said to be ailing for the past few

days. The house was a very poor one, and in a rather dilapidated state, with a damp kind of earthen floor. The second patient was accommodated in a room badly ventilated and badly set up in every particular as regards sanitation. She was *æt.* 18, and her build and constitution would be described as fine and robust. On entering the chamber where she lay I was at once struck by the vividness of the picture her decubitus presented. Her head was quite thrown back in such a way that her occiput seemed to lie between the wings of the scapula. Her knees were drawn up. The respirations were hurried, and the expression on the face was of a very staring, anxious kind, with the palpebral fissure greatly widened and the pupils dilated. Her temperature at the time, which was 4 p.m., was 105°. I at once suspected that what the inmates of this house were suffering from was a meningitis, and that it was of a contagious nature. The picture presented by the grown-up girl tallied in such a way with the classic accounts of cerebro-spinal fever that I had read the latter disease at once occurred to my mind, but owing to the rarity of its occurrence, and never having seen anything like it before, I summoned a consultant, Dr. Morton, Oxmantown Mall, Birr, to my assistance. Before Dr. Morton arrived, I gathered that there were two more children in the same house suffering in the same way, and this latter knowledge at once convinced me that the disease whatever it was was a very infectious one. The parents, it should be stated, seemed very desirous to keep the matter as secret as possible, and screened even from my observation the fact of anyone except the first-named child being ill in the house. Dr. Morton arrived at once, and examined all the four patients with me and agreed with the diagnosis of meningitis of a cerebro-spinal kind. On the following night at 8 p.m., I saw the girl, Mary G., *æt.* 18, and her temperature was 106°. I did not see her again until twelve o'clock noon on the following day, when evidently she was dying. Her temperature at my last visit reached 107°, and she died at three o'clock the same day. The other patients were removed to the local Fever Hospital, and the Local Government Board being duly apprised of the outbreak, sent one of their principal medical inspectors, Dr. Edgar Flynn, to inquire into the matter. The latter gentleman saw the remaining three patients in Birr Fever Hospital, and quite concurred as to the diagnosis made by Dr. Morton and myself in those cases.

The other two cases made a good recovery, and with the exception of a slight squint in the younger of them they are both really very fine children, and apparently none the worse from the attack of cerebro-spinal fever which they underwent.

Transactions of Societies.

BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD THURSDAY, APRIL 13TH, 1905.

The President, DR. WILLIAM ALEXANDER, in the Chair.

PROFESSOR JACOBS, M.D., of Brussels, read an interesting paper on

CANCER OF THE UTERUS.—SURGICAL TREATMENT.—RESULTS.

He said that, before everything else, he desired to tender his thanks for the honour which was done by allowing him to read a paper before the British Gynæcological Society, and also to take part in the proceedings of that celebrated Society. He hoped to show his gratitude for election to the membership of the Society by the establishment of cordial scientific relations between the British Gynæcological Society and the Belgian Society of Obstetrics and Gynæcology.

PROFESSOR JACOBS then read his paper and demonstrated his specimens by means of the epidiascope. This paper we propose inserting in an early number, with illustrations. In the discussion that followed

Professor TAYLOR said one thing which struck him

forcibly was the point which Professor Jacobs had so well brought out—namely, that cancerous deposit was found at a considerable distance from the point of invasion; and this was borne out by the sections on the table. The important point which must strike all practical surgeons was that as experience grew one seemed to find that operations in all cases of cancer were less satisfactory than they should be. Whether the extensive operation described was an advantage or not, he considered had still to be proved. Practical surgeons agreed most decidedly that if operation was performed at all, it ought to be performed early. The second point of interest was as to the beneficial effect, or not, of Doyen's treatment and the truth or fallacy of his theory. As Professor Jacobs had remarked, it was too recent to enable one to judge, but we hoped to have more knowledge of it in the future.

Mr. BOWREMAN JESSETT said the Society was very much indebted to Professor Jacobs for his very excellent paper. It seemed to him, however, that Professor Jacobs' cases were all more or less limited to those where the disease had commenced in the cervix, and as he (Mr. Jessett) had now had 180 cases of vaginal hysterectomy, he proposed, for the benefit of the discussion, to give a brief history of these and their results. (These cases will be found on page 475.)

Miss GARRETT ANDERSON, M.D., said it was a great privilege to have heard Professor Jacobs' most interesting paper, to have seen his sections, and also very interesting to hear what he said about the advantages of the abdominal route over the vaginal. It was particularly interesting to hear that Dr. Jacobs approved of the abdominal route in spite of the fact that the vaginal one was that nearly always selected at the present time.

Dr. MACPHERSON LAWRIE said he would like very much to hear more about the serum of Professor Doyen which had been used for injection in cases of cancer.

Dr. GEORGE ELDER (Nottingham) said one thing which had struck him in the description of the abdominal cases was that the results were certainly no better than those obtained by the vaginal route, and although Professor Jacobs' operative mortality was exceedingly small, something like 3 per cent., he thought it must be attributed to his operative dexterity. Probably no one else, or at least very few, obtained such results as those from the abdominal operation. He had always felt that when he had to resort to the abdominal operation the chance of recurrence was exceedingly great. Patients operated upon by the vaginal route certainly recovered with less shock and much more evenly than those in which one had to resort to abdominal operation.

Dr. THOMAS WILSON said he would like to heartily join in the thanks which had been expressed to Dr. Jacobs for the interesting paper which he had read. Professor Jacobs' results, even in extensive abdominal operations, had, from his own point of view, been deplorable. As a result of an extensive research into German, English, and American literature he made out that the average results of the vaginal operations amounted to 33 per cent. of cures after five years, and that most operators seemed to claim 66 per cent. of cures after five years in body cancer. His own experience taught him that the results of body cancer were not so good as that, but in cervical cancer one certainly got 25 to 30 per cent. of cures if the cases could be obtained early enough. He thought the results of those extensive operations were not good, certainly no better than the results of vaginal operations.

Dr. F. J. MCCANN said that he was opposed to those extensive operations which were now practised in the treatment of carcinoma of the uterus. He supposed that they had been started on the analogy between mammary cancer and uterine cancer, but he submitted that the conditions in the two cases were very different. In the case of the mamma, one could remove the breast and lymphatic glands and the intervening tissues, but if such an extensive operation were attempted to the uterus the conditions were very different, because

of the proximity to the uterus, bladder, rectum and ureters. Therefore it seemed to him that one could never hope for a very extensive operation in the pelvis. He thought supra-vaginal amputation of the cervix had a place in the treatment of uterine cancer. The cases suitable for the supra-vaginal operation were those early papillomatous or polypoid growths of the vagina, which yielded excellent results; for other cases, hysterectomy was the proper treatment. In the case of cancer affecting the cervix, the vaginal was the preferable route, because in that disease one must make an extensive local removal, and it seemed to him that extensive local removal could be done better by the vaginal than by the abdominal route. But there was one thing which the extensive operation adopted on the Continent and in America had taught, namely, that a more extensive removal of the vagina was necessary in cases affecting the cervix, and for some time past he had been in the habit of removing a considerable portion of the anterior and posterior vaginal walls with the cervix. With regard to cancer affecting the body of the uterus, it seemed to him that the vaginal method might still be adopted if the body was not too large, but, if one had to deal with enlargement of the uterine body, it would be better to perform the abdominal operation. Some operators said that in the majority of cases the glands were affected. If that were so one would never obtain such results as were obtained now by vaginal hysterectomy. The difficulty, in his opinion, was that it was not at all an easy matter to distinguish when glands were invaded by inflammatory products, and when they were invaded by cancer.

Dr. A. HELME said it was of far greater value to hear the personal experience of such an honest authority as Professor Jacobs than to study statistics, and he had been profoundly influenced by what he had heard from Professor Jacobs that evening. Although he could go back to one case still living upon whom he operated fourteen years ago, yet his own practice had come to this—that he reserved the abdominal route for selected cases, on the ground mentioned by Professor Jacobs, and he was glad such an authority laid it down definitely that there was a fundal infection in the lymphatics without any intervening local infection. Although Professor Jacobs came and honestly narrated the results of his operations, which as he himself admitted were deplorable, still it was a matter of common sense that the wider the operation which could be done for cases of cancer the better would be the chance which was given by it to the patient to be free from recurrence for a considerable time.

Dr. ARTHUR GILES said that the general consensus of opinion in England was not as yet favourable to extensive abdominal operation. He believed that, from the point of view of theory, the abdominal operation was perhaps the route to be aimed at. But if, as Dr. Jacobs had shown, at an early stage the glands at the brim of the pelvis were unaffected it was obvious that one must be filled with dismay at any prospect of removing the disease completely, even at an early stage. So far, the results with regard to recurrence did not appear to have been any better by the extensive abdominal route than by the old vaginal route, and if it turned out to be that, on the whole, the mortality from operations by the vaginal route was less than by the abdominal route, and that the ultimate results of the abdominal route were no better, he thought that for the present many would cling to the vaginal route, even though they might think that the abdominal route was the one to be aimed at.

Dr. CHRISTOPHER MARTIN would have liked to have heard some fuller details as to the method used in performing abdominal hysterectomy for cancer. With regard to his own experience of vaginal hysterectomy, although he had had no deaths from that for cancer, the result of his cases had been very bad. His impression was that probably nine out of ten cases showed recurrence in two years from operation, and therefore he welcomed any other operation which promised results which were an improvement on those figures.

But he confessed that by the paper that evening he was not at all tempted to go in for the abdominal method. It seemed to him that the mortality was six or seven times as great, or very much greater, and that the ultimate results were equally bad.

Dr. F. A. PURCELL congratulated Professor Jacobs on the small mortality of his operations. Unfortunately his own statistics were not so good as that. He had a series of 265 cases, but the performance of operation on those cases was commenced in 1884, and during the years 1884 to 1886 and 1887 to 1880 he performed fifteen vaginal hysterectomies, in which he had no death. But in the next 50 cases he had 18 per cent. of deaths after operation. Still, year by year, the figures seemed to diminish, for in the next 50 cases he had a mortality of 14 per cent., in the next 50 8 per cent. only, and in the last four or five years the percentage had been brought down to about 6. He had several deaths within six months from recurrence of the disease. Of the 240 who remained living after the operation, 41 died within a year from recurrence. Forty-three died in two years, 46 died in three years, 48 died in five years, and 47 in six years. He had one case which remained alive twenty years after the operation. His percentage of mortality after operation came to 9.43 per cent. over the whole series of years. The average duration of life after operation for the disease, and those which were untraced, was 6.4 years. The ages of the patients ranged between 25 and 74. Still, he was unable to give statistics equal to Professor Jacobs' figure of 3 per cent.

Miss ALDRICH BLAKE thanked the Society for giving her an opportunity of hearing the interesting paper of Professor Jacobs. She was one of the few who had steadily practised for the last four years the abdominal method for the removal of cancer of the cervix. For cancer of the cervix alone she had had 15 cases, and so far there had been no operative mortality. But most of them were too recent to enable her to say much about the final results. Of the four cases operated upon by her during 1902 she knew that three were at present well, and free from recurrence. One was free for one year and four months; but two months later she could feel, high up against the wall of the pelvis, apparently in the glands, a mass which gradually spread towards the vagina. There were two cases upon which she operated similarly in 1903. She had seen both of them recently, and they were both apparently well. There were four during 1904, but they were too recent. None of the cases upon which she had operated had so far had any vaginal recurrence. She had removed an extensive amount—one, one and a half, and two inches—together with the cervix from the abdomen, dissecting out also the ureters on both sides and removing the tissue in which she feared recurrence on each side of the uterus. She hoped to some day bring forward the final results of those cases. The amount of shock was slight and the subsequent progress of the cases was satisfactory so far.

Dr. MACNAUGHTON-JONES, in conveying the thanks of the Fellows to Dr. Jacobs for his valuable communication, said that the compliment which that gentleman said the Society had conferred on him in electing him an Honorary Fellow had been returned in full by the honour he had done it in coming to deliver the address to which they had just listened. It was a subject which touched not only their profession at large, but had a most important bearing on one of the most serious and terrible diseases to which women were subject. He would just make a few brief comments on the paper. In it Professor Jacobs had brought out clearly the certainty of lymphatic invasion in carcinoma. He had also shown the difficulty of reaching the limits of that lymphatic infection by any operation, and, lastly, he had shown that a period of from five to six years must be allowed to elapse before they could fairly apply the term "cure" to any case of cancer which had been operated upon. The experiments of Emil Ries, Wakefield, Gellhorn, Ernst, and Russell had in recent years established clearly certain facts—the identity of the recrudescing structure with the original carcinoma,

the uncertainty of the exact seat of the lymphatic infection, and the stages in the formation of the carcinomatous nodules and epithelial ducts. Emil Ries had made as many as 20,000 sections, and the difficulty of discovering the presence of carcinoma in an enlarged gland was shown in the instance of one case, in which he made as many as 700 sections before he discovered it. It should be remembered that not only by direct lymphatic invasion was the disease disseminated, but that it reached the blood current directly through hæmolymp glands through degenerations in the connective tissue, and, as Mary Dixon Jones had shown, through inflammatory corpuscular changes in it. Gellhorn had shown that the regional pelvic glands were affected in one third of the cases, and that the channel of infection was through the lymph spaces in the nerves. Ernst had proved the same fact, and had injected the entire pelvic lymphatic system from the sciatic nerve. The anatomical bearings of the lymphatic distributions and connections had been largely elucidated during the last few years, and it was indisputable that there were ample means of communication between the affected organ and all the associated glands, from the lumbar to the inguinal. The difficulty in regard to enlarged glands was increased by the fact that such were not often necessarily malignant. With regard to the serum treatment he (Dr. Macnaughton-Jones) objected altogether to any test of any method being accepted which rested upon a dual foundation. If we were to accept the serum method as a cure for cancer we should take such cases as were subjected to it alone, and not those in which it was preceded or succeeded by operative measures. To judge fairly between it and operation, we should have had the results after the periods mentioned by Professor Jacobs in two cases of corresponding severity in which serum and operation had both been relatively tried. It was still entirely premature for any scientific body to venture on an opinion as to the treatment by Dr. Doyen's method. Were it found to be the boon that it was hoped it would be, British surgeons would be among the first to accord to him the honour which such a discovery deserved. Professor Jacobs had said that there was a strong bond of sympathy between the Gynæcological Society of Great Britain and the Obstetrical Society of Brussels. There ever had been a friendly alliance between the two nations that those Societies represented, and if such an alliance existed in a national sense surely it ought also to be found in the science and art of surgery.

Professor JACOBS, in reply, said: I think, gentlemen, that we are inclined to agree. I limited the scope of my paper strictly to cancer of the cervix, for, as we all know, cancer of the body of the uterus is not at all, as regards the danger of recurrence, such a serious affection as cancer of the cervix, and, for that reason, I thought it better not to deal with the two localisations of uterine carcinoma at the same time. I have elsewhere indicated the reasons for the comparative benignancy of cancer of the body of the uterus. I frankly confess that the results which I obtained after vaginal hysterectomy have been discouraging, and that I cannot yet speak of any abdominal hysterectomy which gave me better results with clearing of the pelvis. However, I am convinced that this fact is due to the imperfection of our methods; perhaps by improving the method we might, in the future, hope for better results. The gravity of surgical intervention for uterine cancer still remains more serious by the abdominal than by the vaginal way; but did not we see the same fact in operations performed for other reasons? Remember what were the results of abdominal hysterectomy for fibroids about twenty years ago. The same result may be hoped for in the operation I have just pointed out. If, as a conclusion, I once more urge you to abandon the vaginal way in favour of abdominal hysterectomy, it is because the vaginal operation must necessarily be incomplete, while the abdominal method allows far wider and more perfect interventions which are, up to the present, the most effective means yet at our disposal for attacking

carcinoma of the uterus. Whether the injections of Doyen's antineoplastic serum before and after surgical intervention might protect us from recurrences and give us permanent cures or not, the future alone will decide; accurate and impartial observation of the results alone can elucidate the question.

ROYAL ACADEMY OF MEDICINE IN IRELAND.
SECTION OF ANATOMY AND PHYSIOLOGY.
MEETING HELD APRIL 28TH, 1905.

The President, Mr. E. H. TAYLOR, occupied the Chair.

DR. GILLMAN MOORHEAD gave a lantern demonstration of the anatomy of a

SIRENOMELIAN MONSTER.

The specimen was obtained from the Rotunda Hospital, Dublin, and was born dead at full term. It presented the typical features of a sirenomelus as described by St. Hilaire and others. The anus was represented solely by a slight skin scar placed over the dorsum of the coccyx, and the external genitals by a similar scar in the neighbourhood of the symphysis pubis. The thoracic organs were normal. The large intestine ended blindly in a distended conical sac in the left iliac fossa, and there was no trace of a rectum. The liver, spleen, stomach, and small intestines were normal. No trace of kidneys, ureters, bladder or urachus could be detected. The suprarenal glands were very large, but microscopically normal. There was only one umbilical artery, which arose from the aorta immediately below the pancreas, and passed almost straight forward to the umbilicus. The musculature of the inferior limb was similar to that usually found. The pelvis showed almost complete fusion of the two ossa innominata, only slight foramina being left to represent the outlet; the femora and tibia were also fused, and there was no trace of fibular. The peripheral nerves were apparently normal in almost every respect, and the only peculiarity of the central nervous system was an unusual enlargement of the lumbar swelling. This did not appear to be due to any increase of connective tissue, but rather to a large size of the individual nerve fibres. No abnormality of the brain was detected.

Professor D. J. COFFEY read a paper on the
HISTOGENESIS OF THE GREY MATTER OF THE
CEREBELLUM,

and dealt with the relation of the structural connections to the functions carried out by the cerebellum as a central mechanism of co-ordination. In the mammal at birth the general anatomical formation of the hemispheres and their laminæ is well established. The neurone structure is, however, in a most rudimentary condition. The grey matter of the cortex consists of close-packed layers of cells, which as yet have not asserted their neurone nature. The chromate of silver method reveals nothing of the dendritic growth so characteristic a few weeks afterwards. The layer of Obersteiner, the superficial germinal layer, as described by Herrick and others, consists of small cells in several rows, underneath which a layer of large cells is identified, consisting of elements of Purkinje, but devoid of branching processes, and of others of epithelial or ependyma nature. The latter show a protrusion of vertical, outwardly directed processes, which reach to the surface and form the first clearly recognisable scaffolding, along which the development of the cells produced in the superficial layer is determined. It results from it that the small neurones produced in the superficial layer acquire a vertical orientation, and, becoming bipolar, are gradually made to descend into the cerebellar substance until the cell body lies below the large Purkinje elements. Synchronously with this determination of direction to the cells, which are now the granule cells, there is an increasing ramification of the fibres of the white matter, the different fibres present at birth. These afferent fibres were exhibited in the sections as the only neurone elements stainable in the mammal at birth whose trend could be positively asserted. They acquire their ultimate character as

the "moss fibres" when they have met with the developing granule cell. Other cells derived from the superficial germinal layer, somewhat larger, acquire the neurone differentiation a little later, synchronising with the development of the outspreading dendrites of the Purkinje elements. It would seem that this association in growth determines a horizontal orientation of those latter superficial cells, and that such is probable is borne out by their ultimate relation as "basket cells" to the Purkinje elements. The next neurone, the Golgi cell, does not apparently come from the superficial germinal layer, but lies from the first near the Purkinje element, and its development is related to the later stages of the granule cell development. Its rôle of "accumulator cell" for groups of granule cells suggested by Galag seems most appropriate. The second class of afferent fibres, the tendril fibres, as demonstrated by Galag, are developed in the closest relation to the growth of the Purkinje elements. If, as described by him, they bring cerebral stimuli to the cerebellar cortex, is it possible that, bringing impulses to the protoplasmic substance of the Purkinje cells, rather than to the dermination of the dendrites, they are nutritional, that is, influencing irritability of the protoplasmic substance, rather than bringing impulses which pass further to peripheral organs. This view would accord well with the physiological relation of cerebrum to cerebellum. As the unfolding of this cell structure goes on during the few weeks following birth in the domestic mammals, the completion of the connection coincides with the development of co-ordinating power.

Professor A. FRASER gave a communication on
IRREGULAR FORM AND POSITION OF THE COLON.

In the specimen exhibited (a male past the meridian of life) the position of the large bowel was normal from the cæcum to the splenic flexure, at which point the irregular course began. The bowel from this flexure passed straight towards the terminal duodenum, to the lower margin of which it was attached, then over the structures in front of the vertebral column, along the attachment of the mesentery to which it was adherent, until it almost reached the ilio-colic junction. At this point it formed a long loop, the upper end of which reached up as far as the right vault of the diaphragm, passing in front of the transverse colon, and lay between the muscle and the liver. The terminal end of the loop passed over the pelvic brim on the right side, then formed the pelvic colon and reached the middle line at the beginning of the rectum. In this case then, the left half of the posterior abdominal wall was entirely clear of the colon, and any one expecting to reach the bowel through the posterior abdominal wall would have been disappointed. Almost the whole length of the kidney in front and the psoas muscle was covered by what is called parietal peritoneum. During the last fifteen years every abdominal cavity (nearly 1,500 in number) passing through the School (Royal College of Surgeons) had been examined and noted by him, and he had found frequent irregularities of the ascending, the transverse, and the descending division of the large bowel both in form and position. The most numerous as regards form are due to the formation of U-shaped loops which may be present in one of the divisions in one subject, in two of the divisions in a second, and in all three divisions in a third. As regards position, the transverse colon may reach as high as the left vault of the diaphragm, generally in young powerful males with the stomach empty, or as low down as the pubes, or even the pelvic cavity, in old females. He had also once found the cæcum implanted in the left iliac fossa, and this was no developmental irregularity. In all those cases that was the first time that he had found the left lateral half of the abdominal wall clear of the colon behind.

It is announced that approval has been given for the "Home District London Companies Royal Army Medical Corps (Volunteers)" to be in future designated the "London District Royal Army Medical Corps (Volunteers) London Companies."

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

MEETING HELD THURSDAY, MAY 4TH, 1905.

JOHN TWEEDY, P.R.C.S., President, in the chair.

DR. LESLIE BUCHANAN (Glasgow) read notes of two interesting cases which illustrated the late effects of birth injury to the cornea, and mentioned the fact that he had quite recently seen a third.

DR. LESLIE BUCHANAN showed a series of lantern slides illustrating the changes found histologically in cases of lesion of the choroid. Four cases showed choroidal changes in eyes excised for other reasons. The first was an ordinary case of disseminated choroiditis. In the second active changes were taking place in the pigment epithelium which was proliferating. There were associated changes in the choroid proper, of a kind frequently seen in cases of sympathetic ophthalmia. The third had irregular pigmentation, and sections showed a fibre-cellular deposit on the surface of the retinal pigment epithelium. The last showed black spots surrounded by a lighter aureola. These changes were due to the accumulation of pigment granules in the epithelial cells. Lastly, the formation of the myopic conus was shown in certain cases to be more than a mere stretching of the choroid for a fibre-cellular formation was found in two cases on the surface of the elastic lamina. In one it was highly vascular, and in the other it was greatly degenerated.

DR. A. H. H. SINCLAIR read a paper on "Bjerrum's Method of Testing the Field of Vision, especially as applied to the diagnosis of glaucoma." The apparatus consists of an ordinary perimeter, and, in addition, a large screen made of some very black and lustreless substance, such as velvet. The surface was mapped out with black thread in concentric and radial lines, like an ordinary perimeter chart, so that tracings of one could be recorded on the other. The fixation object was usually placed at the centre of the field, while the test objects were made of white ivory of from 1 to 20 mm., and were held in a clip at the end of a thin black rod, which could be moved about in any direction. This method had several advantages over the ordinary perimeter, for it could be used to investigate the condition of the field within its full limits and often demonstrated minor or relative defects within the field, which are often of great clinical importance and which the ordinary perimeter is unsuitable to demonstrate. Lantern slides were shown exhibiting the condition of the field found in different groups of cases. Glaucoma fields were contrasted with fields taken from cases of optic atrophy. Several tracings were shown in which the glaucoma symptom was demonstrated with the screen, but where the peripheral fields and vision were normal. A series of charts were shown which were obtained at intervals of from six weeks to five years, indicating the permanent nature of this symptom in many cases, and how it might change in others. Other variations of the field in glaucoma in connection with this test were also shown and discussed.

DR. ARTHUR L. BALLANTYNE described the microscopical condition of the left eye of a fœtus of seven or eight months where the pupillary membrane was almost complete, and adherent at one part to the posterior surface of the cornea. The iris was adherent to the cornea in the corresponding situation. The different layers of the cornea were normal, but at the place where the iris and pupillary membrane were adherent the endothelial lining of the anterior chamber was absent, though present elsewhere. The remains of the hyaloid artery and tunica vasculosa were also present. The author attributed the adhesion to an inflammatory process which had led to the destruction of parts of the endothelium of the anterior chamber, and consequently to an intimate adhesion of the walls of the anterior chamber at the affected parts. In discussing the literature he said he had found fourteen cases recorded and two theories were held to account for it. The one was that the cleavage of the mesoblast into substantia

propria of the cornea is incomplete, hence the apparent adhesion of the fully developed membrane and cornea. The other theory was that the adhesion is set up by an inflammatory process between the iris or pupillary membrane and the cornea where these are naturally in contact during foetal life, or subsequently during abolition of the anterior chamber either with or without perforation of the cornea. The author considered that the second theory accounted for most of the cases, and there is a lack of direct evidence in favour of the first.

Mr. S. JOHNSON TAYLOR related a case of
PULSATING EXOPHTHALMOS,

which was cured by ligaturing the common carotid. The patient, a woman, æt. 55, was first seen four years ago, suffering from pulsating exophthalmos on the right side, and a well marked intracranial bruit audible to herself and also, with a stethoscope, to the observer. The bruit came on immediately after a fall seven weeks before, in which she struck the left side of her head against a stone step; she rendered herself unconscious for a few minutes, and at the same time she broke her collar-bone; the proptosis did not come on until four weeks later. She suffered severe pain with corneal ulceration, all of which became worse in spite of rest, iodine, &c. Mr. Johnson Taylor considered it advisable to ligature the right common carotid, and this he did at her own home about nine weeks after the injury. The result was a perfect and permanent cure and no untoward effects ever manifested themselves.

LIVERPOOL MEDICAL INSTITUTION. MEETING HELD ON APRIL 27TH, 1905.

The President, Dr. JAMES BARR, in the Chair.

Dr. A GORDON GULLAN read a note on a case of
HYDATID CYST OF THE LUNG.

The patient, a woman, æt. 38, was admitted to hospital in June, 1903. She was very thin, weighing only 7 stone, and the right lung showed signs of consolidation from the fourth rib to its base, and there was a large cavity in the upper part. She expectorated hydatid cysts varying from the size of a pea to that of a walnut. The sputum on other occasions was muco-purulent. She was given an expectorant mixture, formalin inhalations, and intra-tracheal injections consisting of menthol 10 per cent., guaiacol 2 per cent., olive oil 88 per cent., one to two drachms being injected daily. No hydatids were expelled after July 20th, and the patient made a satisfactory recovery, having since gained 2 st. 10 lbs. in weight.

Mr. COLIN CAMPBELL said he had no experience of the treatment of hydatids of the lung, but could hardly believe that injections of such small quantities of oily solutions could produce much eliminative effect; it would simply float on the contents of the cavity. He had for years employed heavy glycerine solutions, which by displacing muco-purulent secretions in pulmonary cavities, brought antiseptic drugs into direct contact with the diseased tissues.

Dr. HUBERT ARMSTRONG read a note on

THE SECOND DENTITION—ITS MEDICAL ASPECTS.

He dealt with the subject under the following headings:—1. General or local disease as a cause of faulty dentition; 2. Faulty dentition as a cause of general or local disease; and 3. The influence of dentition upon concurrent general disease. Under the first heading reference was made to rickets, cretinism, syphilis, the exanthemata and other acute febrile diseases; adenoids, thumb-sucking, &c. The second section dealt with general symptoms, ulcerative stomatitis, anæmia, dyspepsia and other symptoms and diseases associated with the second dentition; while in the third section the neuroses—epilepsy, chorea, and acute febrile illnesses were briefly mentioned. The importance of good health in ensuring a sound dentition, and *vice versa*, that of a sound dentition to the general health in after life, was emphasised, and it was pointed out how in various

ways the medical man could supplement the effort of the dental surgeon in this double object.

The PRESIDENT exhibited and explained the use of several instruments for recording the blood-pressure.

Dr. W. BLAIR BELL read a note on the

SURGICAL TREATMENT OF CHRONIC CONSTIPATION. He did not consider that ileo-sigmoidostomy was a suitable operation for dilated conditions of the big bowel, owing to the "backing up" which occurred. He thought cæco-plication or excision of the dilated portion of the cæcum more rational. Ileo-sigmoidostomy, however, was valuable in those cases in which the big bowel was contracted, and he related a case of this kind in which he had performed ileo-sigmoidostomy with satisfactory results. He was convinced that one operation, however, could never be successful in all cases of intractable constipation, and that until the various pathological conditions obtaining in chronic constipation were accurately defined and rendered possible of recognition clinically, surgical procedures could not be so carried out on empirical lines.

Dr. W. ALEXANDER, Mr. F. T. PAUL and Dr. R. E. HARCOURT took part in the discussion.

Mr. RUSHTON PARKER showed models of an old Roman catheter, a rectum dilator, and an unguent injector. He also showed drawings, coloured photographs, and lantern slides of a few cases, some unusual, recently under observation. They comprised chancre of the mammary areola, sarcoma of the chest wall recurring after the excision of a cystic adenomyxoma of the breast; a galactoceles containing inspissated milk; the brain and spinal cord from a case of cerebro-spinal meningitis, and a large prostate removed a week previously by supra-pubic cystotomy.

ULSTER MEDICAL SOCIETY.

MEETING HELD (MEDICAL INSTITUTE, BELFAST.)
ON THURSDAY, MAY 4TH.

Dr. J. B. MOORE, Vice-President, in the Chair.

Mr. ROBERT CAMPBELL, F.R.C.S. (Eng.) read a paper on

SURGICAL CLEANLINESS.

There were, he said, still many doubtful points in connection with his subject, but on three propositions he thought all would agree—(1) That septic infection is due to micro-organisms; (2) That these, except in the case of a septic patient, are introduced from without; (3) That they are introduced by objects coming into contact with a raw surface. On a fourth proposition, also, he thought most would agree; that moist heat was the only agent by which these micro-organisms could be satisfactorily destroyed. Mr. Campbell then proceeded to deal with different sources of infection.

1. *The Instruments.*—As regarded these he had nothing special to say, except that he greatly preferred to see them boiled in a fish-kettle, and not trust to steam in a closed steriliser.

2. *The Patient's Skin.*—This he considered of minor importance compared with other sources. He doubted the necessity for days of preparation before an abdominal operation, and thought washing well the night before, covering with a dressing, and washing again before operation was sufficient. It was essential that the skin should be clean, but not essential that it should be sterilised.

3. *Sponges, Sutures, and Ligatures.*—Sponges should be treated with steam for 30 or 40 minutes before use; they presented no difficulty. Ligatures and buried sutures were much more difficult, and no ideal material was known. What we needed was something strong, pliable, aseptic, sterilisable, capable of being absorbed, and fairly cheap. Silk was the best, except that it was not absorbable. Catgut was on the whole the best medium we possessed, and he used it prepared in formaline. He carefully selected the catgut, kept it in 4 per cent. formaline for 24 to 48 hours, according to thickness, washed it, boiled it for 30 minutes, and

kept it in absolute alcohol till wanted, when it was taken out and boiled for five minutes before use.

4. *The Operator's Hands.*—Probably in most cases of infection this is the source. Mr. Campbell considered at length the various means of avoiding infection from the hands, which, it is agreed, cannot be sterilised. In cases where the hands came much in contact with the parts, as in abdominal operations, he prefers rather thick rubber gloves, roughened on the surface, so as to give a better grip.

5. *Other Sources.*—The hair and mouth were then considered, and a light gauze bandage to cover the hair and mouth shown, to be used in long operations.

DR. CECIL SHAW, in criticising the paper, referred to the effect of boiling on the edges of fine instruments, such as cataract knives, and expressed the belief that the damage often done, and attributed to the boiling, was really due to wiping the knife on a hard towel. Nothing should touch the edge but soft chamois leather. Mr. A. B. Mitchell did not agree as to the use of gloves, thinking there was considerable risk of fluid accumulating in the finger-tips under pressure, and being released by the prick of a needle in the wound. Mr. Fullerton agreed with Mr. Campbell generally, but not with his views on the patient's skin. Dr. O'Connell was in favour of a full and careful ritual, which he believed to be safest in the long run, though parts of it might seem unnecessary. Dr. Lynass also spoke.

Dr. GARDNER ROBB, D.P.H., read a paper on "Smallpox in Belfast."

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS May 7th, 1905.

NITRITE OF AMYL IN HÆMOPHYTOSIS.

HÆMOPHYTOSIS, in the course of phthisis, is a well-known accompaniment and of frequent occurrence, and numerous are the agents prescribed to arrest it, all with more or less successful results. Quinine, ergotine, sulphuric acid, ipecacuanha are old-time classical remedies, while a solution of adrenoline in subcutaneous injections has been more recently recommended.

M. Rouget has added to the list of hæmostatics a more simple remedy than the latter—that of nitrite of amyl in inhalation. In ten patients on which he tried it the results were remarkable; in one case the hæmoptysis had resisted every other means. This agent acts indirectly on the pulmonary circulation by lowering the tension and provoking peripheric vasodilatation.

CHLORIDE OF BARIUM IN PLEURISY.

The absorption of one daily dose of 4 grains of chloride of barium in four ounces of distilled water, continued during eight days, provokes the absorption of considerable effusion into the pleura. The action of the agent in heart affections is not as pronounced as that of digitalis; it is purely diuretic and favours the cardiac compensation but indirectly. Chloride of barium can render also some service in nephritis, because it increases the diuresis without irritating the kidney.

FALSE CROUP.

When a child of from two to five years of age has "a cold," and that he is affected with a strident and hoarse cough in the evening, M. Conder recommends that the mother should awaken the child every hour until two o'clock in the morning. Thanks to this stragem the attack of false croup will be avoided.

Awakening the child frequently during the first half of the night was suggested to him by the fact that infants never suffer from false croup. When they have a little cold their sleep is restless, and as soon as they awaken they are given the breast or the bottle. The child should be completely awakened and put sitting up each time the breathing becomes embarrassed and the patient becomes restless, and a warm drink given.

The explanation of his method is easy. During the first two days of the cold, the subglottic mucous membrane of the larynx is more or less inflamed, narrowing thus the passage of the air; besides, at this period,

secretion is but slight, viscous and adherent. During the day, the motion of deglutition and the cough displace the mucus, but during the first sleep the air current dries the secretions and transforms them into a kind of membrane. At a certain moment these mucous membranes hinder or completely obstruct the respiration, and suffocation is imminent.

If, on the other hand, the child is aroused before the secretions have had time to accumulate, and that he cries or is given a drink, the mucosities are displaced, and the threatened obstacle is not realised.

CAPILLARY BRONCHITIS IN CHILDREN.

Take a basin containing three pints of water at 104 deg. and stir in a half a pound of mustard flour until it produces irritating effects on the eyes and mucous lining of the nose—that is to say, about ten minutes. A piece of linen large enough to envelop the child up to the neck is plunged into the liquid. When it is well steeped and wrung, it is then laid on some woollen covering and the child rolled into it. He is left thus for ten or fifteen minutes, or until he becomes restless, indicating that the desired reaction has been obtained. The mustard-cloth is then removed from its body, which is of a bright red. The patient is then sponged with warm water, to remove all traces of the mustard, and is enveloped again in cloth moistened with warm water, rolled in flannel and left for two hours, so as to maintain the cutaneous hyperæmia obtained by the mustard application. At the end of that time a warm bath is given to the patient, who is finally put to bed, when generally he will sleep for hours.

The method is somewhat complicated, but it has been remarkably successful in desperate cases.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, May 7th, 1905.

DEMONSTRATION OF A LARGE GALL-STONE PASSED PER VIAS NATURALES.

At the Society for Innere Medizin, Hr. F. Klemperer showed a patient who had had extreme jaundice for two years, and who in November last passed a large gall-stone 8 ctm. in length, and 4½ in circumference (3½ inch in length by 1½ in circumference). It weighed only 50 grm. It was comprised mostly of cholesterolin. It was passed without trouble, so that the patient was able to continue in service. His condition was not improved, however; on the contrary, he was confined to bed for months. The man had had an acute attack of biliary colic in January, 1903, and became jaundiced the following August. No treatment was of any use, not even a course in Carlsbad, and operation was always declined. After the passage of the stone the liver remained large, not very tender, and the very dark jaundice remained the same. It was suspected that another stone remained, and a few weeks ago one was passed. After that great improvement took place. The liver could now no longer be palpated, the pain was gone, and the jaundice had become much paler. It was believed that the stone lately passed was lodged in the liver. The small amount of disturbance caused by the passing of the stone was worthy of note. Possibly there were more calculi in the liver, but the prognosis was becoming more and more favourable.

Hr. Glucksman spoke on TRAUMATIC DISEASE OF THE UPPER FOOD PASSAGES AND THEIR TREATMENT.

He would only speak of the injuries caused by swallowing foreign bodies, as these were frequently treated too lightly both by the public and the profession. When the body was removed it was concluded that complete recovery would take place. Whilst in reality the removal of the bodies, frequently sharp-cornered, caused laceration of the mucous membrane or deeper structures, and these were liable to infection and might set up fever. In the treatment of such foreign bodies he had become, as time went on, more and more conservative. At first he did not employ any active treatment, and not infrequently the bodies were expelled by the movements of coughing or vomiting

If treatment must be employed it must be appropriate and as limited as possible; an accurate knowledge of the symptomatology of swallowed foreign bodies was necessary. The alarming symptoms generally coming on with the midday or evening meal were not as dangerous as they seemed. The suspected danger of suffocation was what alarmed the patient most. We could most easily calm them by letting them drink water or breathe deeply. Unnecessary persons should be removed, one or two were sufficient for assistance or as witnesses. Questioning the patient cleared the position, as to the kind of foreign body, its situation and the time of swallowing it. He had often seen the tin squeaker of indiarubber dolls as a foreign body, and such like dolls should not be given to children to play with until the squeaker had been removed. If patients on being asked where the foreign body was pointed to the mouth, it might be taken that it lay above the constrictors of the pharynx. It was worthy of note that fish bones could bury themselves in the tonsils, that only a little bit could be seen. The time of swallowing was important to learn, as sometimes patients went to the doctor in the belief that something was sticking in the throat without being able to fix any time of swallowing it, and examination showed a granular pharyngitis in the lower part of the pharynx. Such a pharyngitis might cause the globus hystericus, and this passed away with treatment of the pharyngitis.

After these preliminary inquiries, a local examination might be made, but with the greatest caution, however, as every instrument used implied a possible infection. In cases where the foreign body lay deeper he would first radiograph in order to avoid injuring any possible aneurysm. Mouth and pharynx should be examined by the spatula and mirror.

For extraction Fergusson's fish bone catch was useful, but the coin catcher was a dangerous instrument. For sounding Trousseau's sounds were the best. The ideal treatment was that carried out under the guidance of the eye. This was best done by his œsophagoscope with which one frequently succeeded in feeling, seeing, and extracting so that no other instrument need be introduced. He then described the construction of his œsophagoscope.

Hr. Alexander related the following case. A lady, æt. 52, swallowed a bone of a hare on January 4th last. On the following day the temperature was 38.5 (C) and she had a rigor. The treatment was expectant. The next day the temperature was 40.7 C. in the axilla, the condition otherwise was good and the pulse 90, rising to 110 on exertion. Careful sounding was now determined on on consultation as it was believed that infection had taken place. A sound with a large bulb was used, but no body was felt or any tender spot found. On the following day there was pain under the sternum, and this the patient complained of at the first. After this the temperature fell, the patient recovered and she could now swallow without difficulty.

Sounding when carefully performed did no harm, and it was useful in showing how deep the œsophagoscope had to be passed.

Hr. A. Fraenkel had had a patient who complained of pain in the right side of the throat after eating his dinner. Nothing could be found on examination, but 24 hours later, fluctuation was felt on the right side of the neck, and an incision was made, from which a piece of bone, 3 ctm. in length and 2 wide was extracted. The bone must have wandered through the sinus Morgagni.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, May 7th, 1905.

NEPHRITIC SARCOMA.

LICHTENSTEIN exhibited one case to the Gesellschaft der Aerzte and recorded the history of another that died, which he considered proved the fallacy of depending entirely upon functional disturbance in the diagnosis of kidney disease. In both of

these cases the kidneys were greatly enlarged, but no functional derangement could be detected by the separator. The first case was a male, æt. 35, with nephritic sarcoma; the second case was a man, æt. 20, with extensive tuberculous enlargement. Both of these had been operated on; the first recovered rapidly, but the second died shortly after the operation.

In connection with the same organ Holzknicht criticised the progress made in radiographical diagnosis in nephro-lithiasis, and proceeded to draw attention to several points for the future guidance of other investigators. The first of his remarks referred to the lower roll of the kidney, where it approaches the neighbouring tissues, leaving a specific line of demarcation immediately above the fatty capsule. He thought the same remark might apply to the diagnosis from the ileo-psoas, calculi—which would thus be seen within the nephritic capsule. He considered the functional tests necessary as adjuncts to radial diagnosis. It was often very difficult to differentiate between stones in the uropoietic system, and the intestinal or calcification of the mesentery glands.

Kapsammer questioned the propriety of Lichtenstein's results as he had the second case under his own observation for some time, and found functional disturbance in the left kidney as well as an anatomical and functional change in the right kidney. It is quite possible, however, that Lichtenstein at a later period may have convinced himself with the separator that no morbid changes were present, as many of these cases assume a normal urine when the morbid process is far advanced. His dogma, therefore, cannot be accepted as infallible, although functional changes may be temporarily absent.

Kapsammer reminded the disputants that no particular method could be relied upon and advocated the common clinical factors of physical, chemical, microscopical and bacteriological examinations, combined with catheterisation of the ureters after administering phloridzin or indigo carmine.

PROSTATIC HYPERTROPHY.

Mosykowicz read an exhaustive treatise on the treatment of prostatic hypertrophy by the administration of the Röntgen rays. He exhibited three cases under treatment, on whom he applied the rays once a week per rectum; the prostate in each case was much softened and reduced. In one of the cases he recorded an attack of severe hæmorrhagic cystitis that had occurred since the treatment commenced. He expressed surprise at the effects of the rays on the gland, and particularly on the epithelium of the organ where the greatest changes were visible. The prostate which contains the corpuscula amyloacea, and which consists largely of lecithin, proves conclusively that this constituent of the economy is the principal element attacked by the Röntgen rays. He was convinced that the rays would give excellent results in the treatment of this intractable disease, as the increased volume was due to a morbid accumulation of this most sensitive element to the rays.

LECITHIN.

According to the chemical analysis, lecithin would be the most reasonable drug to offer a patient suffering from rachitis, anæmia, leucocythæmia, tubercle, scrofula, and neurasthenia, owing to the large amount of phosphorus it contains in an easily assimilated form. Pills are now prepared as well as an oily solution for use in these diseases of which one gramme per day is prescribed. By some it is used subcutaneously in the strength of a 5 per cent. solution. The results are yet limited, but those obtained are excellent.

RESULTS OF ATTEMPTED SUICIDE.

Fein exhibited an interesting case to the members. A male, æt. 57, eleven days previously had attempted to commit suicide by hanging himself on a tree; but the cord or string being fine and frail gave way, precipitating him to the ground, where he lay insensible for some time. On recovering consciousness he rose and went home, but found himself speechless, not able to swallow, and associated with severe palpitation. On examining the larynx both vocal cords were

found in the cadaveric position, i.e., midway between extension and contraction, which he attributed to the injury received to the trunk of the vagus nerve, either by crushing or over-extension before the cord gave way. The implication of the heart depended on the same cause, viz., injury to the *nervi cardici*.

Grossmann thought the heart implication depended on injury to the *rami cardici* of the vagus nerve, and not on the trunk or sympathetic of the *nervi cardici*.

ATROPHIA CUTIS IDIOPATHICA.

Riehl showed two skin cases in females. The first, he said, was an advanced stage of idiopathic atrophy, which Pick designated erythemomegalalgia. The second was a similar case, he said, but had the distinctive name of scleroderma, plaques being present under the mamma and upper surfaces of the feet.

Operating Theatres.

ITALIAN HOSPITAL.

OPERATION FOR SQUAMOUS EPITHELIOMA OF THE LOWER LIP.—Mr. LENTHAL CHEATLE operated on a man, *æt.* 45, who had been admitted for squamous epithelioma of the lower lip, situated midway between the angle of the mouth, and the centre of the lower lip. The lymphatic glands below the angle of the jaw in the submental and submaxillary regions were enlarged. The incisions made were one starting from the angle of the mouth, which passed downwards and backwards to the lower border of the inferior maxilla; another incision started from the middle of the lower lip and passed downwards and backwards to the lower border of the inferior maxilla—that is to say, parallel with the first incision. The inferior extremities of these two incisions were joined by a V-shaped incision, the apex of which was situated midway between the hyoid bone and the lower border of the inferior maxilla; from the apex of this V-shaped incision a curved cut was carried backwards to half an inch below the angle of the jaw. The tissue intervening between the two first parallel incisions was removed, and it included the skin and mucous membrane of the lower lip, part of the orbicularis oris, and almost the whole of the depressor labii inferioris muscles. From the other incisions flaps were formed and the enlarged glands underlying the skin in the submental and submaxillary regions were removed, including a portion of the facial artery and the submaxillary salivary gland. The opposing skin surfaces and mucous membranes were joined together. Mr. Cheatle said that cancer of the lower lip spreads round the mouth in the same way as leucoderma and scleroderma in these regions; this being so, the ordinary V-shaped incision described in surgical books does not remove enough tissue; he stated that two so-called recurrences he had seen after removal of the lower lip had been in the skin in the neighbourhood of the V-shaped incision, so he considered that the incisions in the lower lip must be made more parallel. He pointed out that the area mapped out in cancer of the lip and leucoderma and scleroderma corresponds to, the naso-labial nerve area described by Dr. Henry Head.

MIDDLESEX HOSPITAL.

OPERATION FOR PERFORATED DUODENAL ULCER AND DILATED STOMACH.—Mr. KELLOCK operated on a man, *æt.* 53, who had been admitted the same morning suffering from acute abdominal pain accompanied by vomiting. The history he had given was as follows:—He was an estate steward, and had always led an out-of-door life; he had had no serious illnesses except erysipelas

twenty-three years ago. For the last six years he had been troubled on and off by attacks of acute abdominal pain, accompanied by the vomiting of sour fluid. These attacks had only lasted a short time, and had been easily controlled by medical treatment. In December, 1904, he had an acute attack similar to the others, but was unable to take his food; since that attack he had never been really free from pain in the abdomen. The bowels were always very constipated. He had recently been treated at the hospital for dilatation of the stomach, which had been somewhat relieved by medicine and washing out. On the morning of the previous day when was driving in a motor car, he was suddenly seized with excruciating pain which extended across the whole of the upper part of the abdomen; shortly afterwards he was sick, and brought up a small quantity of blood. He was admitted to the hospital on the following morning, and his condition was as follows: He was a fairly healthy-looking man, but with an anxious abdominal aspect; he lay on his back with his knees drawn up, and complained of great pain in the epigastric region; the abdomen was retracted and did not move with respiration; there was tenderness on deep pressure all over the epigastric and hypochondriac regions; the lower part of the abdomen was soft and free from tenderness; no swelling could be seen or felt; he complained of great thirst, also of exacerbation of pain when he took a deep breath. The temperature was about normal; pulse fairly good, not much increased in frequency. The patient having been anaesthetised, the abdomen was opened by a five-inch incision made through the upper part of the left rectus muscle. The stomach, somewhat dilated, presented in the wound, some purulent exudate was found covering the under surface of the liver and the front of the duodenum, and, on separating these two an opening about a quarter of an inch in diameter was at once seen on the anterior aspect of the duodenum about an inch and a half from the pylorus, through which the contents of the bowel were seen to be escaping. This opening was closed by a double row of silk sutures, the first merely closing the opening, the second turning in as far as possible the peritoneal surface; this having been completed, a posterior gastro-jejunostomy was performed over a calcified bone bobbin. A large drainage tube was then passed down to the site of the ulcer in the duodenum, and the abdominal wound closed round this in layers. The patient appeared to stand the operation very well. Mr. Kellock said that one of the most interesting and favourable features about the case was the length of time that had elapsed between the time of the acute perforation and that of the operation without the production of any more serious symptoms than those which had been seen, and this, he thought, had been brought about by the duodenum becoming adherent at once to the under surface of the liver, and so the area affected by the acute peritonitis had been a comparatively limited one. The operation in itself, he pointed out, had presented no great difficulty. The perforation had fortunately been found in anterior aspect of the duodenum, rendering its closure fairly easy. The fact that the patient had been previously treated for dilated stomach, he said, made the performance of the gastro-jejunostomy of double use; it would tend to remedy that condition, and also to give entire rest to the surface of the duodenum which had been affected by the

ulceration. Mr. Kellock trusted that the prognosis in this case was as good as could be hoped for in such a serious condition. The drainage tube which he had inserted was merely, he remarked, as a safety valve in case of leakage from the duodenum, and provided that did not occur, it would be removed in the course of two or three days.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, MAY 10, 1905.

A ROYAL ACADEMY OF BRITISH MEDICINE.

HISTORY tends to repeat itself even in matters medical. In 1870, at a general meeting of the Royal Medical and Chirurgical Society of London, a scheme was approved to form a body, incorporated by Royal Charter, under the title of the Royal Society of Medicine, to consist of sections for the main branches of medicine and the collateral sciences. Into the history of this non-fulfilment we need not now enter. It is for us now to realise that a strong opinion is supporting the aims of the would-be progressives of thirty-five years ago. Last Thursday an important gathering of representatives of many of the leading medical societies assembled at 20, Hanover Square, and was presided over by Sir William Church. Much difference of opinion appears to exist as to the precise manner in which concentration should be effected. It is clear enough that the mere multiplication of societies is disadvantageous to all. It is also evident to many that unless carefully rejuvenated the older bodies sink into complacent conservatism, and may even hamper scientific advancement by their non-progressive methods. It is most apparent to thoughtful minds that association must not hinder individual growth and differentiation. At the meeting to which we have referred a Select Committee was appointed to gather evidence, formulate some practical scheme, and report to a subsequent meeting of the representatives of medical societies. This no doubt is a most desirable method of procedure, and may be expected to result in much that will be of ser-

vice. But the question is one of such vital importance to the progress of medicine in this country that we think the subject should be discussed by the profession as a whole. It is to be regretted that the movement was not initiated by united action on the part of the Royal Colleges of Physicians and Surgeons. At the present time we notice that there are fears that the selection may be dependent on artificial rather than what we would term natural considerations. Some desire only a confederation of London societies. Others plead for an amalgamation of what are conveniently designated Central societies. Many would be satisfied with affiliation, association, or even union of already existing Metropolitan societies. But the progressives, as we may call them, urge the desirability of constituting a new body which might be designated The Royal Academy of Medicine. There are manifold difficulties in the way of evolving any satisfactory scheme for the union of existing bodies. There are important financial difficulties, moreover, which must be apparent to all. Many perplexities would arise from an attempt to secure interchange in the use of buildings, distribution of Proceedings or Journals, and restriction of attendance at meetings. Then again, it must be remembered that some societies, like the Neurological and Physiological are not strictly London societies, but are really travelling British societies. The Anatomical Society widens its borders to include the whole of Great Britain and Ireland. Certain bodies, like the Society for the Study of Inebriety, although essentially medical, also admit laymen as Associates; and the Medico-Legal Society, of course, includes members of the legal profession, who have no medical qualification. And still further, if the new body is to include, by affiliation or otherwise, all approved British medical bodies on what grounds should our Colonial colleagues be excluded? The question bristles with difficulties. It is doubtless quite possible to secure the confederation of certain of the older medical societies of London. We are of opinion, however, that it is most desirable that a Royal Society or Royal Academy of Medicine should be established. But it is quite likely that in asking for the greater we may lose the better. In this case we are not desirous that history should repeat itself. The subject is so important and has such far-reaching influence on medicine in this country that we consider the profession as a whole should take it into earnest consideration.

THE FUTURE OF THE IRISH MEDICAL ASSOCIATION.

AN extraordinary article appears in the pages of the "Journal" of the Irish Medical Association for the present month under the heading "The New Irish Medical Directory." It commences with the statements that the new Directory is "a genuine success," that "it has leaped into immediate popularity," that "one can now get a cheap

Directory of Irish Medical Practitioners only," that "no one has anything to say against the new Directory save those who think to benefit by abusing it," and that "there are no adverse criticisms save from those from whom such expressions might be expected, whose motives in doing so are transparently clear." Further, we are told that "the Directory does not profess to be anything save what its name imparts—i.e., a classified list of Irish Medical Practitioners," that it has been brought out by the Irish Medical Association, and that, as is openly stated, it is intended to be used as a means of forcing men to join the Association. In fact, the article conveys that the "Directory" is a deliberate attempt on the part of the Irish Medical Association to hoodwink the public into believing that the only qualified medical men are those who are members of the Irish Medical Association. We have called this article extraordinary because we understand that the Committee of Council of the Association has only refrained from immediately dissociating itself from the "Directory" because it received an undertaking from the creator of this boycotting list that he would immediately assume entire responsibility for it, and would free the Association from the disgrace of being connected with it. Moreover, we learn that the "Directory" has already caused defections from the Association, and that an undertaking has been given that it should never again appear in a similar form. As to what the work professes to be, we quote from its own advertisement of itself, where it is stated to be "a reliable and accurate record of the profession in Ireland." The author of the article in our contemporary has already consulted a dictionary to find out the meaning of the word "directory," and has given us the result of his search. We now suggest that he should consult it again, and ascertain the meaning of the words "reliable," "accurate," and "record." We must quote one more sentence from an article which marks an entirely new departure in medical politics, and, we fear, an abandonment of medical ethics. It is this:—"Speaking generally, it should be made clear to non-members that if any work is to be done for the profession in Ireland, it must be done through and in the Association." Irish readers do not, as a rule, require any explanation of such words, as they are familiar to them in the mouths of political organisations. Their author must understand what his words mean, but has he any idea of their consequences if carried into effect? The questions at issue are very simple ones. First, is the Association in favour of the policy foreshadowed in its official organ of this month? If it is not in favour of such a course, will it awake to a sense of its responsibilities and enforce discipline in its own house and among its own servants? If it is in favour of "a plan of campaign" will it say so definitely, in order that those members who regard the honour and dignity of their pro-

fession may understand their position? An Association that sanctions a scheme of boycotting in order to enforce membership is no place for honourable men, and if such a policy were adopted its promoters would find that so far from bringing the entire profession within the ranks of the Association they had instead driven out all that was honourable and best. We, too, desire that the Association should include the whole medical profession, but if it is to do so it first must put its own household in order, and it must show the profession that it is determined, first, to maintain the honour and dignity of the Irish Medical Profession, and, then, to work for the welfare of its members. When the Association is established on such a basis it will be no longer possible for its official organ to advocate a policy foreign to the intentions and nature of the Association, or for one of its officials to brand the Association with the discredit of, and responsibility for, a work the like of which has never been published by a body of professional men.

CEREBRO-SPINAL MENINGITIS.

WHILST it is always possible for newspaper scares to be raised, and when raised to be fed with the flimsiest of *canards*, it is important to remember that they are sometimes founded on facts which it is well not to treat too lightly. Cerebro-spinal meningitis is a disease from which this country has fortunately been free, or almost free, for some time, but it is quite on the cards that the sporadic cases of that disease, of which mention is being made in the daily press from time to time, may be the prelude to an increased prevalence, or even an epidemic. The early history of cerebro-spinal meningitis in the British Isles is so inextricably confused with that of other fevers, notably with typhus, that it is not possible on historical evidence to unravel it with any degree of accuracy. In fact, even in 1865, when the disease attracted attention in London, so great an authority as Murchison pronounced it to be closely allied to typhus, and in Ireland at the same time it went by the name of "the black death." Cerebro-spinal meningitis became prevalent again in 1876 in both England and Ireland, but judging from contemporary accounts a great many of the cases seem to have been diagnosed as typhoid fever. The most recent outbreak of the malady was one in Shropshire in 1891, but since then, though sporadic cases have occurred from time to time in the great towns, no epidemic of any magnitude has broken out. On the other hand, France and Germany are well acquainted with cerebro-spinal meningitis, and in America the disease is a cause of some little anxiety to those responsible for the public health. In New York the Board of Health are so much impressed with the danger of the disease that special regulations as to the quarantine of patients and those attendant on them, together with orders as to disinfection, have been issued. In the last few weeks a case of cerebro-spinal meningitis is reported to have occurred in Richmond, another at

Liverpool, three in Irthlingborough, Northamptonshire, and some doubtful ones in Ireland, so that it behoves medical men to be specially on their guard in cases of obscure febrile illnesses, lest this undesirable visitor gain a foothold on our shores.

In the United States the history of cerebro-spinal disease has varied somewhat since it first reached that country from Germany and Switzerland in 1806. At first the disease seems to have been met with only in epidemics, but since 1860 it has settled down to the position of an endemic in most of the large urban centres, with the power, inherent in all endemic diseases, of blazing out into epidemics from time to time. The most recent of these epidemics occurred in 1898 to 1900, and again in 1903 to 1905. To what set of reasons this country owes its happy immunity from cerebro-spinal meningitis epidemiology can give no clue, for there does not appear to be any particular climatic factor at work in the States which is absent from Great Britain. One fact connected with the prevalence of the disease, however, is established—namely, that like small-pox and measles it is a cold-weather affection, in the same way that typhoid and scarlet fever are autumnal. Again, the reason for the predilection of these diseases for certain seasons of the year is obscure, though theories of every description have been invented to fit the facts. The practical point to which attention should be turned, however, is that if, during the hot weather this summer, scattered cases of cerebro-spinal meningitis keep cropping up in different parts of the country, it is quite possible that as the winter comes on a more extended prevalence will mark the progress of the disease. In America, where practitioners have so many opportunities of observing cerebro-spinal meningitis, no decision has been come to as to its precise degree of infectivity, and probably the personal factor plays a comparatively small part—smaller even than in pneumonia. It is, however, undoubted that the ultimate cause of cerebro-spinal meningitis is the *diplococcus intracellularis meningitidis*, at any rate when the disease occurs in epidemic form: some observers doubt whether it causes the sporadic cases, but there has not been sufficient investigation on this point yet to decide. The point of entrance of the bacillus into the system is the nasal mucous membrane, in the opinion at least of many competent observers, but there are those who contend for the intestinal mucosa as the initial point of attack. The former would seem on *a priori* grounds the more probable, for a passage through the Schneiderian membrane to the meninges of the base of the brain would be a short one, and coryza is spoken of as being a frequent antecedent symptom. The entrance into the body, however, is not always through one path, as definite cases are on record in which surgical and puerperal patients have been infected by cerebro-spinal meningitis in a way that suggests strongly the possibility of the specific bacterium having been received through direct absorption from the wounded surface. In recent American

epidemics the majority of all sufferers, as is the case with so many of the infectious complaints, have been children, and it will probably, therefore, be among children that cerebro-spinal meningitis will show itself most frequently if the disease invades these shores. But that such a contingency may be averted will be the earnest desire of all good citizens, for we have already sufficient hygienic nuts to crack without the importation of a fresh one.

Notes on Current Topics.

Paying Hospital Patients at Cannes.

MEDICAL men in the United Kingdom will do well to fight the pay system in hospitals tooth and nail, inasmuch as it constitutes a grossly unfair form of competition by the hospitals against the general practitioner. In our own country large sums are, in many cases extracted from patients; while the injury to the profession generally is accentuated by the further fees handed over to certain privileged members of the hospital staff for attendance. The length to which this iniquitous system can be pushed by unwise philanthropists has recently been admirably illustrated at Cannes. The editor of *Truth* has drawn attention to a recent incident at Sunny Bank Hospital, Cannes, of which Lord Rendel is "Administrateur," and which is supported partly by patients' payments and partly by private subscriptions. It appears that an American journalist, while on a visit to that place with his mother, was taken ill with an infectious disease and removed to Sunny Bank on the understanding he was to pay eight guineas a week. His bill for six weeks, however, amounted to nearly £80. Medical fees came to £21, chemist £2, three francs for a linseed poultice, and six francs for a bandage. These charges would be extortionate for the most greedy and fashionable of London private nursing homes. If the Sunny Bank Hospital at Cannes must be supported in this way, the sooner it winds up as a hospital and starts as an ordinary private nursing home on an ordinary commercial basis the better.

Stockings and Vice.

THE stocking is usually regarded as an innocent and useful garment, and, in civilised countries, indeed, as almost a necessity of dress. It is true that the modern fashion of wearing sandals threatens to destroy the universal use of an ancient and honourable part of costume, but, on the whole, it still retains its dignified place in the economy of clothes. Moreover, the stocking has been proved of manifold utility over and above its normal function of covering the human leg. It has been hallowed for most of us by happy and beneficent Christmas associations. Form any generations, too, in its nook in the chimney-corner it has provided the primitive bank for the industrious who are mindful of the coming rainy day. Its functions, however, have not always been of a peaceful and generous nature. Whether

filled with sand in the hands of the thug, or loaded with a paving-stone and wielded by the doughty mill-girl nearer home, as a weapon of offence it has demanded and received respect. Never, however, from whatever point of view it has been regarded, has the stocking caused such a turmoil as at the present moment in Toledo, U.S.A. It appears that in that advanced city it has just become the custom to exhibit hosiery in the shop windows on what are, we believe, known in the trade as "forms." The result is a display of shapely, well-dressed wooden legs, so attractive, according to certain of the clerical and medical faculties of Toledo, as to draw the mind of the youth of the town in imprudent directions. So grave has the scandal become in the eyes of these grave and reverend seigneurs that they have banded themselves into a "ministerial alliance," the particular object of which is the abolition of the display of women's hosiery in shop windows. Seriously, one would have thought that the clergy and medical men of Toledo could have found some other scope for their energies than a crusade of this sort.

A Surgical Heroine.

At a recent meeting of the Vienna Gesellschaft a woman was shown who had survived a series of grave surgical operations. Her first attention at the hands of the surgeon consisted in removal of "pyosalpinx gigantea with resection of part of ureter." Operation number two was performed to cure a fistula of the bladder opening through the abdominal wall. Number three was a right-sided nephrotomy for abscess of kidney. Number four was a left-sided nephrotomy for calculous pyonephrosis. This was followed by a second right-sided nephrotomy for a similar condition. The final experience of this heroine of surgery was a right-sided nephrectomy on account of a fistula and calculus. Her history affords a striking illustration of the boldness and perfection of modern surgical procedures. It is also gratifying to learn that her sufferings were not in vain as regards the rest of mankind, for the report of the meeting naively states: "This case gave rise to a long discussion on diagnosis, which very forcibly illustrated recent advances in the correct diagnosis of nephritic diseases."

Cerebro-Spinal Meningitis in Lower Animals.

THE occurrence of the epidemic of cerebro-spinal meningitis which is at present raging in New York has naturally turned the attention of epidemiologists to questions as to the etiology and mode of spread of the disease. Although it is now nearly twenty years since the causal agent was discovered, we are still very far from understanding its life history. In spite of the tendency of the disease to occur in epidemics, there are but few recorded instances where direct infection seemed to have taken place. In fact, it but rarely attacks more than one patient in a house, so that the belief is gaining ground that the

contagium vivum is conveyed indirectly and not directly from patient to patient. This naturally recalls to the mind the association formerly noticed between epidemics in the human race and certain epizootics of somewhat similar nature in other animals, an association very much lost sight of since the discovery of the *diplococcus intracellularis*. It is important, however, that in connection with very many of the great epidemics of cerebro-spinal fever during the last hundred years curious epidemic diseases among horses, swine, dogs, foxes and poultry have been noted. Thus, as long ago as 1811, during a serious outbreak of the disease in Vermont, many foxes and fowls perished with symptoms resembling those noted in children. Again, the epidemic in Paris in 1844 was accompanied by an epidemic among livery-horses, and in Algiers, in 1848, by an epidemic among fowl, while the artillery horses at Grenoble in 1841 suffered at the same time as the gunners. A curious incident is related by Low regarding one of his cases in Ireland in 1865. One of his patients, a little boy, had eleven pet rabbits, of which no less than nine died with convulsions and paralytic symptoms.

Hospitals and Casualty Fees.

MR. JUSTICE DARLING is so well known as a legal humorist that his sallies of wisdom are apt to be at times overlooked. A short while since he threw out a practical suggestion of some value with regard to hospital economics. He was hearing an action for damages brought by a plaintiff whose pony and trap had collided with an electric car belonging to the London County Council. It transpired that plaintiff was treated for his injuries at St. Thomas's Hospital, but that no item was set down in his claim for donation to that Institution. The judge observed that plaintiff was a well-to-do man and could readily have afforded to pay something. "People who could afford it," he added, "ought certainly to pay for assistance they received under such circumstances, as the charity of the hospitals was intended in the first instance for necessitous patients." Another aspect of the case is the necessitous medical men outside the hospitals, who are robbed of legitimate attendance on their patients. It is an extraordinary thing that well-to-do persons who are treated for some accident at a hospital appear to consider themselves entitled to all the subsequent gratuitous surgical attention that may be necessary. Any well-conducted hospital would in the first instance bring some pressure to obtain a donation to the charity in recognition of the first-aid service and would then refer the patient to his own medical attendant, and refuse further hospital attendance forthwith.

A "Special" Inquest Fee.

THE *Eastern Daily Press* of April 12th contains the statement that "twenty guineas was reported as being paid to Dr. S. H. Long, of Norwich, for his 'special medical evidence' on the body of a

domestic servant." It adds that two local medical men were also called as witnesses. The latter, it may be assumed in the absence of detailed information, were paid at ordinary guinea rates. We call attention to the matter because it is satisfactory to find that some coroners have the courage to call highly skilled medical evidence and to pay adequate fees in return. As a matter of fact the ordinary coroner finds his hands tied by pressure from the local authorities who have to pay the cost of his jurisdiction. If a weak man he will often decline to hold inquests when they are obviously required, or, again, he will exclude valuable witnesses with a view to keeping down expenses. If the Norwich coroner, however, can pay twenty guineas for the services of a highly skilled medical witness, why cannot any other coroner of the United Kingdom do a similar thing? Mr. Coroner Troutbeck, however much we condemn his unjust and arbitrary methods, certainly does not shrink from piling up costs for the ratepayer. Every time he calls in Dr. Freyberger, it means a special fee, and even Mr. Troutbeck cannot always dispense with the evidence of the general practitioner whom he treats with so much contumely and scorn.

Idiocy and Sterilisation.

THE legislature of the State of Pennsylvania recently passed a Bill directed towards the prevention of procreation by idiots and imbeciles who have been inmates of public institutions. It has, however, been vetoed by the Governor of the State. The intention of the legislature was that procreation should be prevented by castration or vasectomy, but the Bill did not define the means to be employed, leaving the decisions in each case to a jury consisting of a surgeon, a physician, and a neurologist. It is hardly a matter for wonder that the Governor refused his sanction to a Bill which, however laudable its intention, does not seem to have been phrased in such a way as to render its scope and powers clear. A reform of the kind proposed needs very grave consideration before it is entered upon, and it would be a pity were any faults due to haste or carelessness allowed to interfere with the proper working of such a measure. The Governor of Pennsylvania seems, however, to have gone beyond his book in seizing the occasion of returning the Bill to read a lecture to men of science in general and to medical men in particular. Passing over his joke that the Bill, by empowering the special jury to take "the safest and most effective" method of preventing reproduction, would not preclude the cutting off the heads of the afflicted persons if that means—like the well-known cure for rabies in dogs—were considered the "safest and most effective," the Governor points out that "men of high scientific attainments are prone, in their love for technic, to lose sight of broad principles outside of their domain of thought," and that, "anatomists may be willing to gather information by the infliction of pain and suffering on helpless crea-

tures." He also makes the sapient observation that "if idiocy could be prevented by an Act of Assembly we may be sure that such an Act would long ago have been passed and would have been approved in this State, and that such laws would have been enacted in all civilised countries." This piece of wisdom if properly understood by legislatures should prevent the folly of attempting any reform. So silly have been most of the arguments put forward by the Governor that one of his critics has suggested that his opposition to the Bill is based on personal trepidation.

Oysters and Disease.

IT is interesting to recall that the knowledge of the connection between oyster-eating and disease is by no means confined to modern times. In fact, for many centuries the occurrence in Normandy of epidemics of various sorts was assigned to the eating of oysters. It is probable that epidemics of typhoid fever did from time to time originate in this way; though, as there was no distinction made between typhoid, typhus, dysentery, and other conditions, it is difficult to be sure of the accuracy of the observations. As long ago as 1385, oysters came under suspicion as the cause of plague, and in that year the magistracy of Paris consulted the Faculty of Medicine as to whether it would be wise to prohibit the use of oysters as food. Nearly five centuries later a medical commissioner, having been sent to Dieppe to study the cause of an epidemic of "putrid peripneumonic fever," reported that oysters were to blame. A few years later a very serious illness attacked large numbers of the population of Dieppe who had partaken of a ship-load of oysters carried from Caen. It was pointed out, however, that the oysters had been carried in a ship which had been used immediately previously for the transport of a cargo of manure, and that no process of cleansing had taken place. With our modern knowledge of bacterial life, we need not wonder that the ingestion of oysters from such surroundings was followed by symptoms of serious poisoning.

The Yolk-Cure.

AS a so-called "cure" in the treatment of the underfed the yolk of egg is at present being extensively exploited in America. Its nutritive qualities are well known to the profession and the public, while its easy assimilability renders it a suitable food in many conditions of gastric and general debility. For instance, in phthisis, at a time when the patient is anæmic and rapidly losing weight, it is claimed that the proper administration of eggs or their yolks has better effect than any other mode of feeding. The method of administration always requires consideration, and it, of course, varies in individual cases. Thus it is sometimes found necessary to give the yolk by itself, or simply beaten up in milk, tea, or coffee. In other cases it is found better to give it in soup, taken along with whatever kind of meat the stomach will best

tolerate. Over and above its own nutritive properties, yolk of egg is said to aid the digestion both of carbohydrates and of proteids, while even in cases of seriously impaired absorption of fat no yolk is found in the excreta. In placing a patient on a yolk-diet it is well to remember the necessity for administration of salt, and, of course, the need for variety in the "make-up" of the food must be borne in mind.

Pre-operative Anæsthesia.

ALTHOUGH ether and chloroform have taken the sting out of surgical operations, in this age when the sensitiveness of people is exaggerated to a point not hitherto attained in the history of civilisation, there has been substituted for the horror of pain the horror of taking the anæsthetic. However self-controlled and strong-minded a patient, the ordeal of inhaling a volatile drug and feeling its influence gradually obscuring the senses is not a pleasant one, and it may well be that some at least of the sudden deaths during the early stages of anæsthesia are due, in part at least, to fright. Dirk (*Deut. Med. Woch.*, March 9th, 1905) has endeavoured to obviate these unpleasant symptoms, and also to reduce the quantity of anæsthetic necessary to keep a patient unconscious, by giving the patient hypodermic injections some time before the operation. In 260 cases of all ages he has administered one milligramme of scopolamine hydrobromate two hours before the appointed time, followed by 2.5 centigrammes an hour later. After the second injection has taken effect the patient becomes stupid and apathetic, so much so, indeed, that in many cases no further anæsthetic is needed. In any case but little is required, and the pain and nausea that follow the operation are much curtailed. Three deaths followed within a few hours of the operations, but these were all in old people, and could not be fairly attributed to the drugs. Israels followed the same plan in 332 cases, and was equally well satisfied with his results.

Bacteriological Ethics.

MANY undignified disputes have raged over the right to priority in the discovery of new scientific phenomena, and even life-long friendships have been known to be strained by the question whether a new species in the animal or vegetable world should be known to future generations as *Smithii* or *Jonesii*. To a commercial community which only values discoveries for the opportunities they present of making money, such points of precedence appear childish and absurd; but to the scientific worker who labours for renown rather than shekels they are very solemn indeed. If, however, all scientists were animated by the delicate ethical feelings of a certain Pittsburg bacteriologist, of whom we read in a recent number of the *New York Times*, the dispute would take to itself rather the character of that which arises when two Frenchmen have to go through the same doorway. The bacteriologist in question, by rare

good luck, captured, according to the *New York Times*, the germ of "spotted fever," a consummation to which his life's work had gradually been leading up. In passing we may mention that the bacterium had long before been seized and identified by Weichselbaum, but of this detail the reporter seems to have been quite unaware. The point which struck him was the magnanimity of the bacteriologist, for the latter hesitated much to acclaim the victory which he conceived he had achieved. The reason for this hesitation was that the patient had contracted the disease in New York, and therefore to New York the germ by right belonged. Before, therefore, taking any steps towards announcing the discovery, the quixotic bacteriologist decided that he must consult the "authorities" of New York. The germ, it is interesting to note, was blue—and shaped something like a coffee-bean. It is sad to reflect that our investigators who discovered the trypanosomes in sleep-sickness did not consult the Congo "authorities" before telegraphing the news home.

Royal College of Physicians, Ireland.

AT the monthly meeting of the Royal College of Physicians, Dr. Anthony Trail, M.D., LL.D., Provost of Trinity College, Dublin, was unanimously elected an Honorary Fellow of the College. Dr. Trail is the first medical man to hold the high office of Provost, and, as our readers may remember, was recently elected an Honorary Fellow of the Royal College of Surgeons in Ireland. The relations between Trinity College and the College of Physicians are so close that it is most suitable that the head of the one should be an Honorary Fellow of the other.

Radium in Cancer.

THE therapeutic use of radium in the treatment of external cancers, of which so much was hoped, has not proved of much value up to the present, but one is glad to notice that, although the hitherto-employed methods of using it have proved of little avail, observers are trying hard to discover whether there may not yet be means of making it effective. One of the most interesting of these methods is that invented by Mr. Hugo Lieber, of New York, who has managed to obtain a solution of the metal, and with the solution trials are being made at the Flower Hospital. The solution is painted on to the surface of external growths, and into the substance of them, celluloid tubes, coated with the same material, are inserted. It is reported that by this means cancerous tumours have shrunk or atrophied, and further experiments are in progress, in which incisions are made into the growths and radium-painted pencils inserted. Although no successes, or apparent successes, so obtained would warrant any medical man at present in postponing operation, it is justifiable that a full trial should be accorded to them in those hopeless cases in which the surgeon can do no more. It is most important that every

means available should be tried while a vestige of hope remains, if only that patients may be saved from falling into the rapacious maw of those "cancer-curers" who infest society, and who, to the misfortunes of the patient, add the burden of unbearable expense to the relatives.

National Nurseries.

THE question as to the best time for beginning the education of a child can hardly be settled by any parliamentary code. Knowledge must dawn upon the mental horizon in proportion to the infant's receptiveness and degree of development. The bud will not blossom any the sooner for having its petals roughly unfolded, nor will a child's intelligence mature more quickly by attempts to hammer the rudiments of learning into brain-cells ill-adapted at this tender age to receive abstract impressions from the outer world. No good can possibly accrue from the system at present in vogue of compelling the attendance of unfortunate infants under the age of five years in a class-room for so many hours a day. Such remarks as those of Miss Bathurst, formerly an inspector under the Board of Education, in the current issue of the *Nineteenth Century and After*, are none too strong, when speaking of the nervous strain which such attendance entails upon these young children, amounting, in her opinion, to actual cruelty. "Baby after baby," she states, especially in the hot summer afternoons, "falls forward off his seat, banging his forehead against the desk in front, and awakes in tears to find such misfortunes are too common an occurrence for much comfort to be his portion. All that the hard-pressed and exhausted teacher has time to do is to fold the child's arms on the desk in front of him, place his head on them, and coax him to fall asleep again." This is called "education." The idea put forward by the writer is that infants require nurses, not teachers, and, therefore, a nursery should take the place of a school-room for them. Here, at least, freedom of body and mind could be obtained, and lady medical inspectors would find plenty of scope for their powers, if appointed to supervise such institutions.

The Prevention of Beri-Beri.

ALTHOUGH the opportunities for the better diagnosis of beri-beri have greatly increased during the last few years, it cannot be said that we have made much progress in the pathology and prophylaxis of the disease. The general consensus of medical opinion is that it is a contagious malady, and, thanks to the observations of Dr. Hamilton Wright, late Director of the Institute for Medical Research, Federated Malay States, investigations are still being conducted upon these lines. After several years' close study of beri-beri, Dr. Wright firmly believes that it is an acute infectious disease having a definite primary lesion in the gastro-duodenal mucous membrane. He has reported his observations in a recent issue of the *Journal of Hygiene*, in which it is stated that the early symptoms of this affec-

tion are frequently put down to simple dyspepsia, following upon which the more characteristic signs speedily appear. He is also of opinion that the disease is spread largely by the evacuations, and, in support of this theory, tables are submitted showing the number of cases of beri-beri occurring in the Kuala Lumpur gaol during the last few years. Certain new regulations with regard to the hygiene of the prisoners came in force in 1902, and since the prison buildings have been better ventilated and their sanitary arrangements much improved, the case-incidence of the disease has diminished *pari passu*. Assuming that the germ of the malady is ingested with food, no meals are now partaken of in the cells, as was formerly the case, and stringent rules have been enforced in respect to washing the hands before meals. The months between September and March are acknowledged to be those in which beri-beri is most prevalent in the Malay States, yet it was just in these months that such a falling off in the number of cases was observed, coincidentally with the time when the new regulations came into force. As a further prophylactic measure, Dr. Wright suggests that the stools should be disinfected.

A REMARKABLE fact, says the *Standard*, has been brought to light in Nottinghamshire in connection with the registration of midwives under the recent Midwives' Act. In all there are 93 certified midwives who have been registered under the County Council supervision, and of these 25 cannot write or sign their names, while 16 can neither read nor write. If these statements be correct they offer a scathing commentary on the recent Acts. Gross ignorance of this kind could hardly be associated with the higher intellectual qualities necessary for the proper conduct of so complicated and hazardous an undertaking as the superintendence of midwifery cases.

WE are informed that it has been decided that at the next annual meeting of the Irish Medical Association to be held in Killarney on June 7th, a scientific paper shall be read on some subject of interest to the general body of members. We should welcome such a departure with pleasure were it not that the next meeting of the Association has matters of vital importance to discuss, on which there is known to be great divergence of opinion. The Association has to decide its entire future policy and the measures to be adopted to restore and enforce discipline in its ranks. We trust that even for the commendable purpose of scientific discussion, the next meeting of the Association will not be deprived of time required for the discussion and adoption of the measures necessary for its own regeneration.

PERSONAL.

PRINCESS LOUISE has promised to be present at a fete to be held in the grounds of Carnforth Lodge Hammersmith, on Monday, June 19th, in aid of the Hammersmith and District Nursing Association. The Bishop of London and the members for Hammersmith

and Fulham will be present to receive her Royal Highness.

THE KING has been graciously pleased to appoint Dr. William Richard Huggard to be his Majesty's Consul at Davos; and Dr. Frank Holland to be his Majesty's Consul at St. Moritz.

SIR WILLIAM CHURCH has been reappointed to represent the R.C.P.L. on the Cancer Research Commission.

A GIFT of £1,000 from Mr. James Ogden has been given to the Rochdale Infirmary for the endowment of a bed in the male ward, in memory of his two brothers. Mr. Ogden made a similar gift in memory of his mother some time ago.

It is announced that Sir John Batty Tuke, the representative of the Universities of Edinburgh and St. Andrews in the House of Commons, will be opposed at the next election by Mr. John St. Loe Strachey, editor of the *Spectator*.

DR. GUSTAV FRITSCH, of Berlin, has arrived in Brisbane for the purposes of anthropological research. He is on a tour of the world by order of the German Government, with the intention of studying the aboriginal tribes, particularly as to the eyes and hair.

DR. C. H. WISE, of Walthamstow, has been appointed to the Commission of the Peace for the county of Essex, and Mr. William Jackson, M.D. Brux., D.P.H. Cantab., L.R.C.P. Edin., barrister-at-law, to the Commission of the Peace for the borough of Nelson, Lancashire.

THE May dinner of the Aberdeen University Club, London, will be held at the Trocadero Restaurant on Wednesday, May 17th, at 7.30 p.m. The Very Rev. John Marshall Lang, D.D., principal of the University of Aberdeen, will be in the chair.

MR. SHEPHERD, of Rosscend Castle, has given £10,000 to Gray's Hospital at Elgin, which is his native town.

PROFESSOR J. W. BYERS has been appointed to represent Queen's College, Belfast, at the International Congress of Obstetrics and Gynecology, to be held in St. Petersburg next September.

At the meeting of the Medical Society of London, to be held on Monday, May 8th, there will be a discussion on the Perineal and Suprapubic Methods of Prostatectomy, to be opened by Mr. Reginald Harrison.

THE next session of the General Medical Council will begin on Tuesday, May 23rd, the first occasion on which the President, Dr. Donald MacAlister, will take the chair at 2 p.m.

THE Congress on Quackery, which was to have been opened in Paris on May 8th, under the presidency of Professor Brouardel, has been postponed till April 30th, 1906.

THE annual meeting of the Asylum Workers' Association will be held at 20, Hanover Square, W., on Friday, May 19th, at 4 p.m., under the presidency of Sir John Batty Tuke, M.P.

MR. WILLIAM HOLBORN, of Campden Hill, has bequeathed £2,000 to the Home for Incurables, Putney.

THE Provost and Senior Fellows of Trinity College, Dublin, have conferred upon Mr. George H. Keene, M.B., the degree of M.D., *stipendio condonato*, in recognition of his distinguished services rendered to Russian sailors at Chemulpho last year, when the *Variag* was destroyed in a naval encounter with the Japanese.

PROFESSOR E. J. McWEENEY, M.D., F.R.C.P.I., delivered an interesting lecture in Cork, under the auspices of the Cork Branch of the National Association for the Prevention of Consumption. The subject chosen was "Tuberculosis: Its Cause and Prevention." The lecture was delivered in popular form, and was illustrated by limelight diagrams. The President of the Queen's College, Cork, occupied the chair.

MR. ANDREW TODD, M.D., and Mr. Edward Magennis, M.D., have come forward as candidates for the representation of Convocation on the Senate of the Royal University of Ireland. They state that the Senate displays a want of attention towards the recommendations of Convocation, and that should they be elected they will endeavour that such recommendations are fully and seriously considered.

DR. J. W. BYERS, M. D., Professor of Obstetrics and Diseases of Women in the Queen's College, Belfast, has been appointed to represent his College at the International Congress of Obstetrics and Gynecology, to be held in St. Petersburg in September next. We trust that political events in that much-disturbed Capital will not interfere with the success of the Congress.

DR. GEORGE A. HERON will deliver the Introductory Lecture to the Post-Graduate Summer Course, at the Central Out-Patient Department of the Mount Vernon Hospital, 7, Fitzroy Square, W., on Thursday, May 18th, at 5 p.m. The subject is: "Some of the Problems to be solved in our efforts to eradicate Tuberculosis."

Special Correspondence.

[FROM OUR OWN CORRESPONDENT.]

GLASGOW.

THE MEDICAL PROFESSION AND THE PHARMACY ACT.—A meeting was held on the afternoon of the 2nd inst., in the Medical Club, Carlton Place, of the office-bearers of the four divisions into which the city was mapped out for carrying on the work of the British Medical Association. Dr. James Hamilton, chairman of the Southern Division, presided. The purpose for which the meeting was called was to consider the recently framed Pharmacy Act, which in its present form largely concerns many members of the medical profession in the City who keep open shop, as well as others, perhaps, who have their private dispensaries. The Act certainly seriously affects those medical men who have open shops for the retailing of drugs, necessitating them employing qualified assistants or alternatively dispensing their own prescriptions personally. In country districts it is not apparent how the Act would work without entailing considerable hardship on the general practitioners in remote parts, many of whom could not possibly afford to employ a qualified chemist. In the discussion which took place it did not seem to some of the gentlemen present quite clear as to the exact position of those medical men who have private dispensaries—the wording of the Act being occasionally rather vague—although it is generally thought there is no intention to apply the Act to private dispensaries kept by medical men for supplying their own patients with medicines. On the motion of Mr. Richmond, Chairman of the North-Western Division, the further discussion of the subject was postponed for a month, to allow the Act to be studied more in detail by those present.

EXPERIENCES AS A PRISON MEDICAL OFFICER.—An interesting gathering of medical students was held in Queen Margaret College, Glasgow, on the 1st inst., when the members of the University Medico-Chirurgical Society met, by invitation, the ladies of the similar Society of Queen Margaret College, to hear a lecture by Dr. F. J. Charteris on "Experiences as a prison medical officer." Dr. Charteris, having been introduced, said that the particular prison with which he was connected was Barlinnie, known as the "Hydropathic" to

habituals, on account of its healthy site, being placed on a hill, and thus in contradistinction to Duke Street prison, which has a very low situation. There are no convicts in Barlinnie, most of the prisoners being what are called "short-sentence men." This prison harbours only men, and therefore the task of keeping order is comparatively easy. As many of the men had been drilled in the militia, they conformed to discipline very readily. It seemed to the lecturer one way of keeping men out of prison was to get them, when boys, to join the Boys' Brigade, as he had never come across any prisoners who had been members of that estimable body. As regards the feeding of the prisoners, the diet was good and abundant. Breakfast consisted of 8 ounces of oatmeal, which would make about two pints of porridge, with buttermilk; dinner, soup and 8 ounces of bread, with tea and supper similar to breakfast. One strange fact noticed was that a small man, about 9 stone, would gain weight on this diet, while a big man about 12 stone, would lose weight. However, to a man acquainted with the routine of the prison, there were ways of getting this diet improved; for instance, if a man came into the prison weighing 12½ stone, and a short time afterwards he only weighed 12 stone, he would complain that the diet was injuring his health, and would thus get something additional. The men took advantage of the opportunity for medical treatment very readily; if a man got a slight scratch while at work he would wish to get special treatment and allowed off work. There were many cases, too, of malingering but they usually were very easily treated, as when a man came up with a pretended sore arm, in a sling, and was immediately told by the doctor that it was no use scheming, he usually simply drew his arm out of the sling and went away, not in the least disturbed! Dr. Charteris thought that imprisonment did not seem to have much of a deterrent effect upon the prisoners, and that to him prisons had their greatest use in the fact that while the men were in prison the public were safe from their attacks. A hearty vote of thanks was accorded Dr. Charteris for his interesting lecture.

LECTURESHIP ON PHYSIOLOGICAL CHEMISTRY IN GLASGOW UNIVERSITY.—Dr. Edward P. Cathcart has just been appointed to the above Lectureship by the University Court. The chair was endowed by the late Dr. John Grieve, Glasgow. Dr. Cathcart graduated M.B., Ch.B., in 1900, at Glasgow University, and in 1904 obtained the M.D. degree with honours. After graduation he served one year as Physician and Surgeon in the Western Infirmary, thereafter going to Munich, where he studied chemistry and bacteriology for six months under Professor Martin Hahn, and Physiological Chemistry under Professors Voit and Cremer. He also studied at Berlin University. He gained in 1903 the appointment as research student in Pathological Chemistry in the Lister School of Preventive Medicine and obtained the post of assistant bacteriologist to the same institution in February last.

Correspondence.

PARTICEPS CRIMINIS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It is probable that most of the readers of THE MEDICAL PRESS AND CIRCULAR will support you in the views expressed in your leader in this week's number of your journal on Modern Advertising at St. Bartholomew's Hospital.

The question of interest which will probably occur to some is whether the Medical Staff of the Hospital can be regarded as entirely free from the charge that "the whole incident forms a scathing satire on modern hospital methods." There is not the least doubt but that the present malpractices of our hospitals are to a great extent due to the conduct of the medical staffs, and that they cannot avoid the charge of being particeps criminis.

I am, Sir, yours truly,
ONE OF YOUR READERS.

DIRECT REPRESENTATION ON THE GENERAL MEDICAL COUNCIL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It is not with any hostile intention that I venture to remark upon Dr. Leonard Kidd's address. But he puts some prevalent beliefs in very distinct language. He calls the General Medical Council the "governing body of the profession." Nothing could be more inaccurate. Its duty is but to see to education. It pays a Registrar to enter in a book the names and addresses of qualified practitioners, and every ten years appoints a Pharmacopœia Committee. There is not much "Governing" there. There is also an underlying fallacy that the General Council is analogous to the House of Commons, which latter can reform itself. But it will not signify in the least whether five out of thirty-five, or one half, or the whole of the members of the Council of Medical Education and Registration, are elected by the practitioners generally, they can do no more than the present Council. They could not touch upon the greater number of the reforms Dr. Kidd advocates. The one great reform that is wanted is to enlarge the powers of the Council, by some kind of scheme of devolution. Any reform, even the slightest, will take years to accomplish, when it requires a special Act of Parliament to bring it about. The Bill of the British Medical Association does nothing to undo the limitations within which the General Council is confined. It adds to its duties some of very doubtful importance. Whatever the Dublin Division may think of the Bill, it has fallen very flat in this part of the world. And rightly so, because it would perpetuate the present cumbrous procedure of referring very minor matters to our over-burdened houses of legislature. This aspect of the question, however, I could not express nearly so well as it has been by your correspondent, Mr. Hy. Sewill, in your last issue. At the same time it is far from desirable that all the members representing Ireland on the General Medical Council should come from one city only, and we must therefore welcome Dr. Kidd's candidature and wish him success.

I am, Sir, yours truly,

G. E. CRICHTON.

96 Earl's Court Road, London, W.,

May 3rd, 1905.

THE ASSOCIATION OF MEDICAL DIPLOMATES OF SCOTLAND.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The letter of the President of the above Association should be in the hands of every Scotch diplomate. There are many practitioners holding the qualification of a Scotch College in London, and many more in England, Scotland and Wales. It is the duty of every diplomate to join this Association, which is one of self-help and of self-encouragement. As honorary Secretary of the Society, I have found that not a few Scotch diplomates are inclined to take a selfish view of the matter, and to ask what good they can get individually out of the Association. To that I reply that there is no knowing how and in what manner the fact of belonging to such a body may be of the greatest value. For one thing, it brings together with a common bond men who otherwise would be absolutely unknown to each other. In these days of rapid developments, moreover, fresh impulses and fresh causes may spring up at any moment. Neglect of organisation in the past has notoriously led to many of the wrongs with which the medical profession is now saddled, such as unrestricted competition by hospitals and by quacks, monopoly of many hospital appointments by London men, a non-representative General Medical Council, and qualification by a hundred portals instead of by one.

Yours faithfully,

DAVID WALSH, M.D.

Hon. Sec. A.M.D.S.

18A, Hanover Street, London, W.

A MEDICAL REFORM BILL.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—Mr. Henry Sewill's paper, as one would expect, is powerful and to the point. It seems impossible to evade his contention that the whole matter of quacks and quack practice should form the subject of a Royal Commission of Enquiry before attempting legislation. Public opinion, for one thing, requires education upon these points. The evils resulting from illegal medical practice are incalculable, but at the same time they are only dimly realised by the man in the street, even when he happens to be exceptionally intelligent and well educated. Men of the highest intellectual culture are ready to trust their minor ailments to the tender mercies of a chemist, a bone-setter or even to the chance and hazard of a quack pill or potion. Clergymen are notoriously amongst the worst offenders in this direction. By all means let us have a Royal Commission. There are signs that the British nation, satiated with blood and conquest in other lands, will turn its attention once more to urgent domestic reforms. What matter if the humane interference of the medical profession be attributed to selfish motives? Self-protection among the lawyers has been worked to such purpose as to form the strongest trade union that ever existed at any period in any country. Yet one does not hear them taunted with that fact? I trust Mr. Sewill will pursue his most excellent mission.

Yours truly,

Croydon.

A STARVING G. P.

Obituary.

CHARLES C. R. TICHBORNE.

We regret to record the death of Dr. Charles R. C. Tichborne, LL.D., a well-known analytical chemist and scientist. Dr. Tichborne, though not in medical practice, was a Licentiate of the Royal College of Surgeons, and was closely connected in many ways with the medical profession. The more important of his professional distinctions may be summarised as follows: Diplomat in Public Health, R.C.S.I.; Fellow of the Institute of Chemistry; late Lecturer on Chemistry, Carmichael College of Medicine; ex-Examiner in Chemistry, University of Dublin; Consulting Chemist, Apothecaries' Hall of Ireland; Gas Examiner, Board of Trade; ex-President of the Pharmaceutical Society of Ireland; Honorary and Corresponding Member of the Philadelphia College of Pharmacy; Honorary Member of the Chicago College of Pharmacy; Honorary Member of the Royal Society of Pharmacy, Brussels; Analyst to the County of Longford; Analyst to the Sanitary Association. He also represented the Apothecaries' Hall on the General Medical Council, and to his advocacy and support that body probably owe to a great extent the continued recognition of their examinations. Dr. Tichborne contributed largely to the scientific journals and to the transactions of the Royal Irish Academy. He was a member of the Pharmacopœia Committee of the General Medical Council, and took an active part in the construction of the Pharmacopœia of 1898. He published a work in conjunction with Dr. Prosser James on "The Mineral Waters of Europe." Dr. Tichborne also worked hard at the industrial developments of scientific knowledge, and amongst other things he invented an instrument for scientifically determining the hardness of stone, and patented an apparatus for the utilisation of carbonic acid gas given off during fermentation. More recently he had been engaged in work in connection with the purification of coal gas. His loss will be long felt by the many bodies with which he was connected, and by his family.

LT.-COL. HENRY ADEY, M.B., C.M. EDIN., I.M.S.

LIEUT.-COL. H. ADEY, of the Indian Medical Service, retired, has recently died at West Kensington, at the age of fifty-four. Educated at the University of Edinburgh, he took the M.B. and Ch.M. degree in 1872,

and entered the Indian Medical Service in October, 1877. He served in the Afghan War in 1879-80; in Southern Afghanistan, for which he had the medal; in the Egyptian Expedition of 1882, when he was present at the Battle of Tel-el-Kebir, and was awarded the medal with clasp and the Khedive's bronze star; and in the operations with the Zhoob Field Force in 1890. He retired in October, 1897.

JOHN PANTON, M.B., C.M. EDIN.

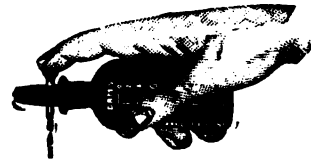
MANY will regret to hear of the death of Dr. John Panton, eldest son of Mr. John Panton, V.S., at the early age of thirty-seven. Dr. Panton was of a quiet and unassuming disposition and a general favourite among all with whom he came in contact. His career from boyhood had been successful. He studied at Edinburgh, where he passed the various examinations with great credit. After graduating M.B., C.M. he held several important assistantships in England, and some years ago took over a practice at Seedley, near Manchester. Dr. Panton was greatly esteemed, and much sympathy is felt for his parents and relatives.

New Appliances.

A NEW TRUSS.

We have received from Mr. Richard Rae, truss maker, of 56, Richmond Road, Shepherd's Bush, W., a truss of his own design. It represents a creditable effort to do away with the need of perineal straps, which are, at best, an uncomfortable necessity. The pressure is obtained by means of wire springs, which rise posteriorly from a pad over the gluteal muscles, and passing above the iliac crests—give support to the pads, which tie over the inguinal canals. These springs are adjustable by bending to any ordinary extent, and by their modifications any required degree of pressure can be obtained. We have given a trial to one of these trusses and we find that it promises to act satisfactorily in certain classes of herniæ. Fat people and those with skins that chafe easily will find the absence of perineal straps no inconsiderable advantage.

CHLOROFORM DROP BOTTLE WITH REVERSIBLE STOPPER.



THE above illustration shows a new form of chloroform drop bottle, introduced by Messrs. Arnold and Sons, which possesses certain advantages over those at present in use. It is of simple construction, no screws or washers are used, the tightening of stopper is solely effected by a careful grinding into the neck of bottle. The stopper is made of galalite, a new patent composition which, being light in weight and clean, is not affected by chloroform or ether. The metal air funnel passing through the centre of stopper and terminating in a curved metal tube inside the bottle is so adapted that either a free flow of the anæsthetic or a discharge in single drops only, can be produced; this, by raising the finger from the funnel or by holding it pressed on same. In the latter instance the air current gets interrupted with the result as described. By reversing the dropper the opposite end of stopper serves to close bottle hermetically. Thus a supply of chloroform is readily at hand whenever required.

NEW POISON-BOTTLE.

We have received from Dr. Reilly, of Catford, a new pattern of poison-bottle which he has designed himself. It consists of two parallel cylinders which communicate throughout their length, and is appropriately named the "Duplex, or Twin Safety Bottle." There should

be no chance of mistaking it, even in the dark, for an ordinary medicine-bottle, and it can be made in all shapes and sizes. The price, we are informed, is moderate.

Literature.

SURFACE ANATOMY. (a)

THIS little book is intended, as its author states, to fill a gap in the series of text-books necessary for the education of medical students. That such a gap exists can be denied by no one who has had any experience of either anatomical or clinical teaching, and that, in spite of the chapters on surgical anatomy that are to be found in all the larger anatomical works.

Mr. Rawling's book is a praiseworthy effort to produce what is required, and is presented in a most attractive form, but although it possesses many excellent qualities, and will doubtless prove of use to numerous students, we fear that it has also some defects which will prevent it from becoming widely popular. One of these faults is that the subject is treated in the form of disjointed and unconnected paragraphs, resembling more notes taken at a lecture than deliberate writing for publication. This is of course necessary to some extent, owing to the nature of the subject, but when carried out all through it proves wearisome. Another fault is brevity, and this the author apparently acknowledges, for he states in his preface that any omissions will be repaired in a future edition. We hardly think, however, that this admission is a sufficient excuse for the sketchy manner in which some of his work is done. A characteristic feature of the book is its numerous and artistic illustrations, but, here again, one cannot help feeling that photographs of a more muscular and less graceful subject would have better suited the matter in hand, and in any case that the figures would have been more striking if less cumbered with unnecessary lines.

There are many other points to which reference might be made, as, for example, the method adopted of subdividing the abdominal cavity, but we fear that we have already said too much, and would end by expressing the hope that a second and altered edition will soon be forthcoming.

ESSENTIALS OF CHEMICAL PHYSIOLOGY. (b)

"The Essentials of Chemical Physiology" has stood the test of many years, since the appearance of the first edition, and has proved to be a veritable godsend to teachers of chemical physiology. Its popularity among lecturers, demonstrators, and students is proof positive of the capabilities of its celebrated author, and thousands of students have, by its aid, been enabled to acquire a sound and comprehensive knowledge of the rudiments of chemical physiology. This new edition is certain of a warm reception, as in addition to the vast store of information contained in previous editions, there is added a "new first lesson on the detection of the elements contained in substances of physiological interest, and thus a link is made in the work of the student who passes from the study of pure chemistry to that of chemical physiology." Some of the advanced lessons have been re-written and the author has apparently been successful in his object of bringing the work abreast of recent advances in science, at the same time keeping it within moderate limits—a task requiring no little skill.

BALLANTYNE ON ANTENATAL PATHOLOGY. (c)

IN the volumes before us, Professor Ballantyne has worthily finished the very heavy task which he commenced with the companion volume on "The Foetus."

(a) "Landmarks and Surface Markings of the Human Body." By Louis Bathe Rawling, F.R.C.S.E. London: H. K. Lewis. 1904. Price 5s. net.

(b) "The Essentials of Chemical Physiology." [By W. D. Halliburton, M.D., F.R.S., R.C.P., Professor of Physiology in King's College, London. Fifth edition. Pp. 266—xi, with 83 illustrations. London: Longmans, Green & Co. 1905. 4s. 6d. net.

(c) "Manual of Antenatal Pathology and Hygiene: The Embryo." By J. W. Ballantyne, M.D., F.R.S.E. Pp. xx—997. Edinburgh. Wm. Green & Sons. 1904. Price 21s. net.

The present volume consists of two parts, the first of which deals with the pathology of the embryo, and the second with the pathology of the germ. We have thus in the two volumes an exhaustive work dealing with almost every phase of intra-uterine pathology. Naturally, in a subject on which so little is known, there is ample room for speculation, indeed our present knowledge, such as it is, may be said to be founded on speculation; and both in this domain and in the surer one of the anatomical and definite facts which are known, the author proves himself to be an admirable expounder. Not only is he full of old world lore and well acquainted with the various fancies and theories by means of which humanity has for centuries striven to account for variations from the normal type, but he is also deeply read in the scientific literature of the present day.

The most interesting part of the present work is perhaps that which deals with the description of teratological types. It occupies some eighteen chapters and, as a work of reference both to recorded anomalies and their bibliography, it is of great practical value. Dr. Ballantyne devotes a chapter to the very difficult matter of teratological classification.

He deals fully with former classifications, and suggests one of his own which is in part based on Taruffi's. Up to the present time, we fancy that the classification of the St. Hillaires has been most usually followed, and if we can dissociate their terminology from its zoological use the classification imparts a better idea of teratological anomalies than in our opinion does any other classification with which we are acquainted.

Dr. Ballantyne's book is essentially a work of reference of a very high order. Its fault, if we may say so, is that it is perhaps unnecessarily complicated. Dr. Ballantyne has such an enormous number of speculations and facts to lay before his reader that, in order to introduce them all, he is at times obliged to blend the two. Whereas it would have tended to greater clearness in writing if he had resolutely set himself to keep them apart.

A word of praise must be given to the illustrations, printing and paper, which are in all respects admirable.

SURGICAL PATHOLOGY. (a)

ALTHOUGH on the same lines as its predecessors, the present edition has been in great measure rewritten, and a considerable amount of new matter added. Moreover, the scope of the work has been enlarged by reference to pathological specimens other than those in the museum of St. Bartholomew's Hospital.

For the information of those who are not familiar with the general plan of the work we may explain that it was originally intended to increase the usefulness of the unrivalled pathological collection at St. Bartholomew's Hospital. Starting with a short general account of the various surgical affections, the morbid appearances and the natural history thereof are illustrated by reference to selected preparations. From this point of view it is an invaluable aid to the practical study of pathological appearances and *pro tanto* it is, we believe, without a rival. Just as anatomy can only be properly learned in the dissecting room, so pathology can only be thoroughly grasped in the *post-mortem* room, and the museum. Studied in this way pathology is a study replete with interest, whereas studied exclusively in books, it is as dry and arid as—say *materia medica*.

The size of the volume may appal the willing student, but the print is large and the greater part of the text is devoted to the description of the specimens referred to in illustration of the particular condition under consideration.

SURGICAL OPERATIONS. (b)

THIS new edition of a well-known manual has been

(a) "Walsham's Handbook of Surgical Pathology." Edited by Herbert J. Paterson, M.A., M.B., B.C. Cantab. F.R.C.S. Eng., Assistant Surgeon to the London Temperance Hospital, &c. Price 10s. 6d. net. London: Bailliere, Tindall and Cox. 1904.

(b) "The Students' Handbook of Surgical Operations." By Sir Frederick Treves, Bt., K.C.V.O., C.B., F.R.C.S., &c. London: Cassell and Co., Ltd. Price 7s. 6d.

revised by the author, assisted by Mr. Jonathan Hutchinson, jun. Based on the author's "Manual of Operative Surgery" it is intended for the use of students preparing for examinations, and everything foreign to that object has been rigorously excluded. The reader is credited, for instance, with the necessary knowledge of surgical anatomy and is supposed to be familiar with the nomenclature of the surgeon's armamentarium. Moreover, no attempt is made to discriminate between the value of the various alternative procedures. It will be seen therefore that the work is, strictly speaking, a guide to operations on the cadaver.

We are told, it is true, that the handbook concerns itself only with the most essential and most commonly performed operations, but surely hysterectomy belongs to that category. Apparently the author holds that there are gynaecological, as distinct from surgical, operations, a concession we hardly expected.

The author's treatment of the subject does not lend itself to criticism, indeed, their names are a sufficient guarantee of the quality of the work. The text is rigorously laconic and the directions are brief and to the point. Even the practitioner, once he has decided upon the choice of procedure, will find these brief, masterly descriptions of the operative measures very helpful. The whole field is covered in less than 500 pages, and the descriptions are elucidated by some 120 illustrations, judiciously selected from those contained in the larger manual. The work, we imagine, is likely to command popularity with students.

Literary Notes and Gossip.

A LITTLE work entitled "Poisonous Plants of all Countries," by Mr. Bernhard Smith, has just been published by Messrs. John Wright and Co., of Bristol. The book aims at being a mere catalogue of the poisonous plants with a short description of each variety. A few brief hints on the treatment of poisoning by the different classes of drugs are interleaved among the descriptions. The list of plants seems to us to be pretty complete, and the work will be found of service to those who take a special interest in toxicology.

RATHER late in the day we have received the Rarveian Oration for last year, by Dr. Richard Caton, and it is interesting to note that the printers are the "University Press of Liverpool." Dr. Caton adopted the unusual course of dividing his address into two parts. The first of these deals with the records of I-em-hotep, the Egyptian God of Medicine, about whose origin and worship Dr. Caton has collected much evidence from original sources. Seven beautiful photographs of the I-em-hotep and his temples are given, and they add much to the value of the book. The second part of the address deals with Dr. Caton's well-known views on the preventive treatment of valvular disease of the heart. The Oration thus presents a curious blend of ancient and modern learning.

"In Watchings Often." By the Rev. E. E. Holmes. (London: Longmans, Green and Co.) consists of an attractive collection of religious addresses delivered at the annual retreats held at St. John's House, a branch of the Nursing Sisterhood of St. Peter's, Kilburn. As the Bishop of Lincoln intimates in the preface, these addresses should be found of real help to professional nurses, to parents, servants, and others who, not being nurses by profession, yet have nurses' work to do, and to the aged. The teaching and manner of presentation is that of the so-called High Anglican. The volume will do much to strengthen many for either suffering or service.

THE "St. Thomas Hospital Reports for 1904" is almost the model of what a hospital report ought to be. Indeed, its only fault is its somewhat tardy appearance. It contains full accounts of the work

done in all the special departments of the hospital, tabulated in such a way as to be easy of reference, while at the same time sufficient information is given regarding the individual features of each case. In addition there are articles on several special subjects, of which the most notable is that by Messrs. Edward Corner and Percy Sargent, on "Volvulus of the Cæcum." The volume as a whole is very creditable to its editors, Dr. Hawkins, and Mr. Battle, and worthy of the great institution whose work it records.

THE *Calendar* of the Royal University of Ireland for 1905 has recently been issued. It furnishes full information regarding the curriculum and constitution of the University in a readily accessible form. The paper and type cannot be described as pleasing.

Medical News.

Medical Sicknes and Accident Society.

THE usual monthly meeting of the Executive Committee of the Medical Sickness Annuity and Life Assurance Society was held at 429, Strand, London, W.C., on the 28th ult. In the absence of Dr. de Havilland Hall, the chair was taken by Dr. J. Brindley James, and there were also present Dr. J. Pickett, Dr. J. W. Hunt, Mr. Frederick Wallace, Mr. F. Swinford Edwards, Dr. Fredk. S. Palmer, Dr. W. Knowsley Sibley, Dr. St. Clair B. Shadwell, Drs. F. J. Allan, and J. B. Ball. The annual report, to be presented at the meeting to be held at 11, Chandos Street, Cavendish Square, on the 18th inst., was discussed. The accounts show that the Society is growing steadily in financial strength, the funds having been increased during the year to the extent of over £10,000, although more than £800 has been paid away in cash bonuses to members who have attained the age of sixty-five years in sickness-benefit. Over ten thousand pounds has been disbursed during the year in sickness claims but notwithstanding this the Sickness Fund has grown from £80,310 to £85,763. Prospectuses and all information on application to Mr. F. Addiscott, Sec., Medical Sickness and Accident Society, 31, Chancery Lane, London, W.C.

Royal College of Surgeons, Ireland.

ELECTION OF EXAMINERS.—At a meeting of the President, Vice-President, and Council the following Examiners were elected:—

Examiners in Anatomy.—Patrick Joseph Fagan, Alexander Fraser.

Examiners in Surgery.—F. Conway-Dwyer; Andrew Fullerton, Thomas E. Gordon, R. Lane-Joynt.

Examiners in Physiology and Histology.—Charles Coppinger, E. L. L'Estrange Ledwich.

Examiners in Pathology and Bacteriology.—Robt. Allen, Arthur Hamilton White.

Examiner in Midwifery and Gynaecology.—Frederick W. Kidd.

Examiner in Biology.—John J. Burgess.

Examiners in Ophthalmology.—Arthur H. Benson, Patrick W. Maxwell.

Examiner in Sanitary Law and Vital Statistics.—H. Benson Goulding.

Examiner in Engineering and Architecture.—J. Charles Wilmot.

Examiners in Chemistry and Physics.—Edwin Lapper, Robert J. Montgomery.

Examiners in Dental Surgery and Pathology.—George M. P. Murray, William G. Story.

Examiners in Mechanical Dentistry.—William Booth Pearsall, Daniel L. Rogers.

Examiner in Languages.—L. J. Woodroffe.

Examiner in Mathematics, Physics, Dictation, and English Essay.—J. W. Tristram.

Serious Charge against a Cardiff Medical Man.

DR. WILLIAM PATRICK BROOKS and Arthur Stanton Price, chemist, were committed for trial at Cardiff on a charge of performing an illegal operation on Hilda Gladys Harris, aged fifteen. Price was further charged with a criminal offence on the girl

The operation was alleged to have been performed at Price's house by Dr. Brooks, in the presence of Price, who subsequently, on the advice of Dr. Brooks, gave her ergot. Bail refused.

Royal College of Surgeons of Edinburgh.

THE fourth centenary of the Royal College of Surgeons of Edinburgh will be celebrated on July 19th, 20th, and 21st. The following is the official programme: *Wednesday, July 19th, 9.30 p.m.*—Reception of Honorary Fellows Elect by the President and Fellows in the Royal College of Surgeons. (Full evening dress.) *Thursday, July 20th, 10.30 a.m.*—The Honorary Fellows Elect, Fellows, and guests will meet in Parliament Hall. (Academic robes, official costume, or uniform.) Admission by ticket only. 11.30 a.m.—Service in St. Giles's Cathedral, to which a procession will start from Parliament Hall at 11 a.m. 4 p.m.—Ceremony in the M'Ewan Hall. Address by the President. Presentation of congratulatory addresses. Conferring of Honorary Fellowships. Doors open at 3 p.m. Organ recital at 3.30 p.m. (Honorary Fellows Elect, Fellows and guests will be expected to attend in their academic robes, official costume, or uniform.) Admission by ticket only. 9.30 p.m.—Evening reception in Royal College of Surgeons. (Full evening dress or uniform.) Admission by ticket only. *Friday, July 21, 3.30 p.m.*—Reception in the grounds of George Heriot's Hospital. Admission by ticket only. 7 p.m.—Banquet in the Music Hall. (Court dress, uniform, or full evening dress.) Dinner tickets for Ordinary Fellows one guinea. Fellows of the College who desire to attend the celebration are requested to intimate the fact, and state at which of the ceremonies it is their intention to be present, to the Honorary Secretary, Fourth Centenary Celebration, Royal College of Surgeons, Edinburgh, on or before June 1st, 1905. After that date it may be impossible to guarantee tickets for the various functions.

The Royal University of Ireland.

Second Examination in Medicine, Spring, 1905.

The examiners have recommended that the following candidates be adjudged to have passed the above-mentioned examination:—

Upper Pass.—Donal Barry, Robert Cox, B.A., Caroline J. Crawford, Edward Dowling, William D. O'Kelly.

The above candidates may present themselves for the further examination for honours:—

Pass.—David R. Acheson, Joseph H. P. Boyd-Barrett, John P. Cahir, Alexander W. Connolly, Peter P. Connolly, John Devereux, Charles Dixon, John R. Elwood, Edmund H. Flanigan, Thomas J. Hollins, B.A., Joseph G. Johnston, Thomas Kennedy, William P. McArthur, Samuel W. McComb, Robert J. McFeeters, John P. J. McGivern, John J. McGrath, Michael McNiff, Daniel J. Magee, B.A., Hamilton Mathewson, Michael J. Mulligan, Charles Murphy, Patrick J. O'Brien, B.A., David O'Sullivan, Robert H. Robinson, Michael White, John M. Williams.

To be exempt from further examination in Practical Chemistry.—Arthur J. W. Compton, B.A., Victor L. Connolly.

The Third Examination in Medicine.

The examiners have also recommended that the following candidates be adjudged to have passed the above-mentioned examination:—

Upper Pass.—*Daniel Boylan, *James B. Butler, Matthew F. Caldwell, Gault Calwell, Joseph P. Carólan, John J. Hickey, *Rowland Hill, B.A., Thomas S. S. Holmes, Patrick O'Hart, Herbert H. Prentiss, *Daniel T. Sheehan.

Those marked with an asterisk may present themselves for the further examination for honours.

Pass.—Thomas Arnold, James Barrett, William F. A. Carson, Joseph Costello, M.A., Cecil R. Crymble, Francis T. Dowling, William S. Graham, William T. Henderson, John Hughes, Joseph McCausland, B.A., Wiclif McCready, Charlotte E. Mitchell, John F. O'Brien, John J. O'Reilly, William L. O'Reilly, Humphrey J. O'Sullivan, James Sinclair, William Whitfield.

The M.B., B.Ch., B.A.O. Degrees Examination, Spring, 1905.

The examiners have recommended that the following candidates be adjudged to have passed the above-mentioned examination:—

Pass.—James F. Byrne, James G. Campbell, Patrick F. Cawley, Robert Chambers, LL.B., Harry Gill, William Godfrey, John C. Hart, James Houlihan, B.A., Thomas Laverty, Frank A. McCammon, John W. McFarland, Samuel McMurray, John J. O'Keefe, Samuel Porterfield, B.A., Jane E. Reynolds, Thomas Rouse, Michael V. Shanahan, Robert J. Spence, George W. W. Ware, William J. Wilson, B.A.

M.D. Degree Examination.—David R. Campbell, B.A., M.B., B.Ch., B.A.O., John S. Cargin, M.B., B.Ch., B.A.O., John Clements, M.B., B.Ch., B.A.O., Hugh B. Steen, M.B., B.Ch., B.A.O., John A. Williams, M.B., B.Ch., B.A.O.

University of Durham.

At the Convocation held on April 20th, 1905, the following degrees were conferred, viz:—

Doctor in Medicine.—Anthony Bradford, M.B., B.S., Annie T. Brunyate, M.B., B.S., John W. Caton, M.B., B.S., Thomas M. Clayton, M.B., B.S., B.Hy., D.P.H., Flora Murray, M.B., B.S., Alfred H. Proctor, M.B., M.S., Oswin Shields, M.B., Thomas C. Visser, M.B., B.S.,

Doctor in Medicine for Practitioners of Fifteen Years' Standing.—James K. Couch, M.R.C.S., L.R.C.P., Louis Demetriadi, F.R.C.S.E., L.K.Q.C.P.I., L.F.P.S.G., D.P.H., Herbert Ed. Deane, M.R.C.S., L.S.A., Frederick W. Lewitt, M.R.C.S., L.R.C.P., John A. Ward, M.R.C.S., L.R.C.P., L.S.A., Francis H. Weekes, M.R.C.S., L.S.A.

Bachelor in Medicine (M.B.).—Dudley T. Birt, James A. Bennett, John F. Bridge, William H. H. Croudace, Lillie Johnson, B.Sc., Frederick W. Kemp, Bernard W. Lacey, Thomas W. Maddison, Aurelius V. Maybury, M.R.C.S., L.R.C.P., Andrew B. Raffle, Charles D. Relton, Leslie M. Rosten, M.R.C.S., L.R.C.P., Olga A. Schiele, Alan Ayre Smith, M.R.C.S., L.R.C.P., Ernest C. Young.

Bachelor in Surgery (B.S.).—Dudley T. Birt, James A. Bennett, William H. H. Croudace, Lillie Johnson, B.Sc., Frederick W. Kemp, Bernard W. Lacey, Thomas W. Maddison, Aurelius V. Maybury, M.R.C.S., L.R.C.P., Andrew B. Raffle, Charles D. Relton, Leslie M. Rosten, M.R.C.S., L.R.C.P., Olga A. Schiele, Alan Ayre Smith, M.R.C.S., L.R.C.P., Frederick Spicer, M.D.Dur., M.R.C.S.

Bachelor of Hygiene (B.Hy.).—K. T. Matthew, L.M. and S.Madras, D.P.H.Camb.

Diploma in Public Health (D.P.H.). viz:—George F. Darker, M.R.C.S., L.R.C.P.; John C. Venpiker, M.D., B.S.Durh., James M. Ferguson, L.R.C.P., and S.Ed.

THE Childhood Society holds its eighth annual meeting to-day (Wednesday, May 10th), at 7, St. James's Square, London, S.W., and an address on Teaching "Commonsense" in the School of the Future will be delivered by Professor H. E. Armstrong, Ph.D., LL.D., F.R.S. The chair will be taken at 3 p.m. by the President, Earl Egerton of Tatton.

Dr. W. PAGE MAY will deliver a course of ten lectures at University College, London, on "The Structure and functions of the Central Nervous System." This course is open to medical practitioners without fee on presentation of their cards, as well as to internal students of the London University. The first lecture will be delivered to-day (Wednesday) at 5 p.m., and continued on succeeding Wednesdays, at the same hour.

Dr. H.V. ASHBY, of Manchester, has been selected to deliver the Wightman lecture on "Some of the Neuroses of Early Life" before the Society for the Study of Disease in Children, on Friday, May 19th, in the room of the Medical Society of London. This meeting will be open to all members of the profession.

Notices to Correspondents, Short Letters, &c.

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

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 re-forwarding 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.

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.

KIDLAND (F.L.S.).—Labour colonies have not yet been established on a firm basis. One of the chief difficulties has hitherto been the impossibility of making them self-supporting. There would be little difficulty in finding work for the unemployed in large schemes for reclaiming and cultivating waste lands, to say nothing of road-making, afforestation, sea-defences, harbours and other national works. Sooner or later the mere multiplication of the population of the United Kingdom and the growth of the labouring classes will force a solution of labour colonies and of other labour problems upon the legislature.

DR. W. H. WHITE.—The rational plan would undoubtedly be to have a bacteriologic examination made of the discharge. You will then have specific data for further guidance. It seems unlikely that ordinary drugs will meet the case you describe. Try Dr. W. O. Syme's little monograph on "Bacteriology in Everyday Practice."

STUDENT (Westminster).—Pharyngotherapy is a somewhat barbarous term coined to express the treatment of maladies of the pharyngeal region. It is most usually applied to that particular form of such treatment involved in irrigation of the naso-pharynx in infectious diseases. Many authorities regard that region as a common area of specific invasion.

PATERFAMILIAS.—The only proceeding necessary is to put up a door-plate. It would be preferable first to call on the medical practitioners in the neighbourhood.

THE ANNUAL GENERAL MEETING of the Medical Defence Union, Ltd. will be held at the Medical Society's Rooms, 11 Chandos Street, W., on Thursday, May 25th, at 5 p.m. to receive the Annual Report for 1904, &c.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MAY 10th.

DERMATOLOGICAL SOCIETY OF LONDON (11 Chandos Street, Cavendish Square, W.).—5.15 p.m. Demonstration of Cases of Interest.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. J. Oastlin: Clinique. (Surgical.) 5.15 p.m. Dr. W. S. A. Griffith: The Prevention and Treatment of Post-partum Hemorrhage.

CENTRAL LONDON THROAT AND EAR HOSPITAL (Gray's Inn Road, W.C.).—5 p.m. Demonstration: Dr. Wylie: Naso-Pharynx.

THURSDAY, MAY 11th.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Titchborne Street, Edgware Road, W.).—8.30 p.m. Paper, Dr. H. Walsham: On the Use of the Roentgen Rays in the Diagnosis of Diseases of the Chest (with lantern demonstration).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique: (Surgical.) 5.15 p.m. Mr. E. Morrison: When would You Operate?

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Lecture Demonstration: Dr. H. D. Rolleston:—High Arterial Tension, its Results and Prevention.

FRIDAY, MAY 12th.

BRITISH RHINOLOGICAL, LARYNGOLOGICAL, AND OTOLOGICAL ASSOCIATION (11 Chandos Street, Cavendish Square, W.).—4 p.m. Cases will be shown by Dr. Abercrombie, Dr. Kelson, Mr. M. Collier, and Mr. Nourse. Communication.—Dr. G. C. Wilkin: The Prevalence of Adenoids in the Child-life of this Country.—Mr. M. Collier: On Treatment of Intermittent Nasal Obstruction.

CLINICAL SOCIETY OF LONDON (20 Haverover Square, W.).—8.30 p.m. Papers.—Dr. S. Phillips: A Case of Typhoid Fever with Pneumonia due to the Typhoid Bacillus (with specimen and microscopic sections exhibited). Mr. J. Hutchinson, jun., and Mr. H. Lett: (1) The Operative Treatment of Certain Cases of Fracture of the Astragalus; (2) A Series of Cases of Fracture of the Astragalus and Os Calcis.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Dr. StClair Thomson: Clinique. (Throat.)

TUESDAY, MAY 16th.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Mr. H. W. Carson: Diagnosis of Appendicitis

Vacancies.

East Sussex County Asylum, Hellingly.—Assistant Medical Officer and Pathologist. Salary £175 per annum, with board, lodging, washing, and attendance. Applications to the Medical Superintendent.

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, 43 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, 43 High Street, Rochester.

Small Hospital in the Midlands.—House Surgeon. Salary £100 per annum, with board, &c. Applications to Mr. P. W. Walker, 18 Waterloo Street, Birmingham.

Northampton General Hospital.—House Surgeon. Salary £100 per annum, with furnished apartments, board, attendance, and washing. Application to C. S. Elabe, Secretary-Superintendent.

Parish of Leicester.—Resident Assistant Medical Officer Poor-law Infirmary. Salary £110 per annum, with ratings, furnished apartments, and washing. Applications to Herbert Mansfield Clerk to the Guardians, Poor-law Offices, Leicester.

The Carnegie Dunfermline Trust.—College of Hygiene and Physical Training.—Medical Man qualified to lecture in Anatomy, Physiology, and Hygiene. Salary £200 per annum. Applications to the Secretary, Carnegie Dunfermline Trust, Dunfermline.

Lister Institute of Preventive Medicine.—Assistant Bacteriologist to the Serum Department, Elstree, Herts. Salary £200 per annum, with furnished rooms. Applications to the Secretary, Lister Institute, Chelsea Gardens, S.W.

Tower Hamlets Dispensary, White Horse Street, Stepney, E.—Male Resident Medical Officer, Salary £150 per annum, with furnished rooms, coals, gas, and attendance. Applications to J. H. Sequeira, Esq., M.D., 63 Harley Street, W.

Administrative County of Somerset.—Consulting Medical Officer of Health. Salary £15 per annum. Applications to H. M. Bennett, Clerk of the Somerset County Council, Frome.

Appointments.

BOND, FRANCIS T., M.D. Lond., M.R.C.S., F.R.S. Edin., Medical Officer of Health of the Chippenham Urban District.

COOK, JOSEPH BASIL, M.D., B.Ch. Vict., M.R.C.S., L.H.O.P. Lond., Assistant Medical Superintendent to the Kensington Infirmary, Marlborough Road, W.

HAMMOCK, W. I., F.R.C.S. Eng., Surgeon to the Ophthalmic Department of the Brompton Hospital, Wandsworth Common, S.W.

HOPE, WILLIAM MOORE, M.R.C.S., L.S.A., D.P.H. Eng., Medical Officer of Health of the City of Gloucester.

JAYNES, ROBERT, F.R.C.S. Eng., House Surgeon to the Royal Eye Hospital, Southwark, S.E.

KELLY, C. I., L.S.A., Certifying Surgeon under the Factory and Workshop Act for the Fortumna District of the county of Galway.

Births.

ELLIS.—On May 3rd, at Newcomen Lodge, Dartmouth, South Devon, to Dr. and Mrs. Clarence I. Ellis—a daughter.

REYNOLDS.—On May 4th, at 31 Bellam Hill, S.W., the wife of Leonard G. Reynolds, M.R.C.S., of a daughter.

WHITE.—On May 3rd, at 112 Harley Street, W., the wife of G. B. Mower White, M.B., B.S., &c., of twin girls.

Marriages.

ROCKE-HARRISON.—On May 3rd, at All Saints' Church, Clifton, Bristol, Thos. Owen Rocke, elder son of the late Rev. Thos. Owen Rocks, of Clungrunford, Salop, to Selina Mande, second daughter of Alf. J. Harrison, M.B., &c., &c., Failand Lodge, Clifton.

WITT-COALBANK.—On May 2nd, at St. Alban's, Teddington, Charles Frederick Hyde Witt, second son of Tansley Witt, of Teddington, to Kathleen, daughter of Isaac Coalbank, M.R.C.S., of Teddington.

Deaths.

COWE.—On May 4th, at 118 Stephen's Green, Charlotte Elizabeth, the dearly beloved wife of Samuel McCutchan Cowe, L.R.C.P., L.R.C.S. Edin., to the inexpressible grief of her husband and family.

HILL.—On May 7th, at Guy's Hospital, Lt.-Col. Charles Birnie Hill, L.R.C.P. Lond., M.R.C.S., Nelsley, Hunt's, eldest son of the late George Birnie Hill, Deputy Inspector General of Hospitals and Fleets.

LE BLANC.—On May 2nd, at Hingham, Norfolk, Mrs. Frederick Le Blanc, widow of the late Frederick Le Blanc, and sixth daughter of Godfrey Jacobs, M.D., of Halifax, Nova Scotia.

O'BRIEN.—On May 3rd, at the residence of his grandmother, Leslie Smith, youngest son of Christopher M. O'Brien, M.D., 29 Merriion Square.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX"

VOL. CXXX.

WEDNESDAY, MAY 17, 1905.

No. 20.

Original Communications.

CANCER OF THE UTERUS. SURGICAL TREATMENT. RESULTS.

By PROFESSOR JACOBS, M.D.,

Secretary, International Congress of Obstetrics and Gynaecology,
Brussels.

It is not my intention to describe the history of the struggle between surgery and cancer with its increasing mortality. The surgical treatment of cancer has two essential objects—the total ablation of the infected organ, and the exeresis of the whole of the lymphatic territory liable to invasion by the cancerous process, having due regard to the anatomical relations of the part. In cancer of the breast these principles are fully admitted by all surgeons. There is not, however, the same agreement in the treatment of cancer of the uterus. The discussions at the Congresses at Paris in 1900, at Giessen in 1901, at Rome in 1902, and again at Paris in 1904 showed this disagreement very clearly. Many surgeons report the most remarkable results, which others consider merely palliative; while a number of those who perform the most extensive mutilating operations are obliged to confess they obtain discouraging results. Some on considering already acquired knowledge operate with the object of making existence more tolerable for their unfortunate patients.

The difference in the results is due to several important reasons: in the first place, there is no general agreement as to the diseases which are classified under the term cancer. In Germany, adenoma is considered a cancerous growth; in France, the opposite opinion is held; in some countries patients will seek advice on the first suspicious symptoms and have an operation performed at the outset of the disease, in others, as Belgium, the patients are not seen by the surgeon until every other therapeutic measure has been tried and surgical intervention is advised in order to divide responsibility, as it is frequently only a question of medical scepticism or simply negligence in examination. Finally, there are countries where cancer is terribly frequent and a frightful mortality recorded, while in others it is rarer, less malignant and more easily cured. I do not wish to develop these few general remarks any further, lest I should weary you; they must not, however, discourage us, nor must we, in view of the actual results of our radical intervention, admit we are defeated and abandon the large and extensive operations by which, as being the most improved method, we oppose the invading march of cancer and return to the more simple operations of older times. In spite of the results obtained, I still remain a partisan of intervention being made as extensively as possible from the starting point of the disease, because I am convinced that cancer is an infection coming from outside, and the sooner we operate the greater is the chance of removing the focus of infection. So long as medical men and a fortiori patients hesitate before the gravity

and curability of cancer, the results will always be uncertain. We will simply repeat the words of a French surgeon because we could not better sum up our belief: "All our wishes in this struggle tend to the hope that we may find operative measures superior to those which we actually possess, but until we do find them our only weapon is surgical intervention."

We must hope, too, that in bacteriology and serotherapy we may, after so much disappointment, find a certain and definite cure where now we are only able to report death or recurrence. With reference to this hope I will give in detail the results of Doyen's researches which I have myself controlled; they are of sufficient importance to deserve serious examination. Whether the theoretical conception of an operation be more or less satisfactory does not matter unless that operation attains its object. This is the reason which induces us to examine the results obtained a long time after the operation. We are not going to consider the statistics of all our colleagues, but I will give the results I obtained in several series of cases in which the operative indications were almost identical. They extend over three periods; one during which high resection of the cervix was performed (1889-1891) in 13 patients, 12 of these showed recurrence in the course of the year following operation, and one 15 months later.

During the second period (1891-1897) I practised systematically vaginal hysterectomy, adding to it the successive improvements which, for a few years, made this a standard operation in the treatment of several genital diseases. In 81 cases, 80 recovered from the operation and one died (1·2 per cent.), 10 cases were lost sight of, while in the remaining 70 cases—

During the first year there were 49 recurrences	70%
" second " 9 "	13%
" third " 11 "	17%
" fourth " 1 "	1·4%

Not one of my patients was alive four years after the operation. These results differed from those of others published at the time and discouraged me as to the utility of my operations when patients of other surgeons were reported as surviving for eight, ten, twelve and even a greater number of years.

At that time I was bold enough to say in the *Revue de Chirurgie Abdominale* of Pozzi, that vaginal hysterectomy must be abandoned in the treatment of carcinoma of the cervix; that our ideal ought to be a more extensive, more radical and complete operation, such as is done in cancer of the breast; in other words, that we ought systematically to have recourse to abdominal hysterectomy completed by cutting out as much as possible of the infected pelvic lymphatic territory, and I had the satisfaction of seeing several surgeons following my opinion. Several years have passed and numerous experiments have been made since then, so that now we can actually see the right way and conscientiously keep to it. These are the results up to 1904: 95 operations with 6 deaths, a mortality say of 6·3 per cent.; 6 patients have been lost sight of. Of the 89 remaining 87 are dead, 2 only are still alive, that

is to say, two actual cures 14 months and 11 months after the operation.

During the first year there were 48 recurrences—	50	$\frac{0}{100}$
.. second ..	20	$\frac{0}{100}$
.. third ..	4	$\frac{0}{100}$
.. fourth ..	2	$\frac{0}{100}$
.. fifth ..	2	$\frac{0}{100}$
.. sixth ..	1	$\frac{0}{100}$

The later results of operation depend upon the indications accepted by the operator as justifying intervention, and this principle is more especially true in cancer of the uterus. For this reason my own results alone are given and no other statistics except those of my private clinic. If, as has been said, anything can be proved with figures, then figures are especially dangerous in dealing with the late results of operations in cancer of the uterus. It is evident that if two surgeons differ even a very little in the indications they accept for operation their results must also differ.

Gentlemen, we conscientiously believe we have followed in all cases related in these statistics the same operative indications, that is to say, the carcinoma has been strictly limited to the lips of the cervix, the cul-de-sac intact, the uterus movable and the general health complete. In other words a selection has been made of patients, except perhaps for the first 15 or 18, where, during the operation, the disease was found to be too far advanced to allow any hope of recovery. Notwithstanding this, there are only two cases without recurrence up to the present.

We believe more than ever that the abdominal route is the proper one in cancer of the cervix and, remembering our opposition to the opinion that abdominal hysterectomy is to be advised only when the vaginal operation is impossible, we still further narrow its limits. Cancer must be operated on only at its very commencement; if any invasion of the parametrium is noticed, no operation can be more than palliative. If it be true that from the histological point of view we may consider that there are two varieties of carcinoma; the squamous-cell carcinoma of the vaginal portion of the cervix and the adenocarcinoma of the body of the uterus, and if it be also true that these varieties of cancer differ in their method of invading the neighbouring organs, there is nevertheless no difference in their modes of invasion of the lymph glands; there is not a special lymphatic system for each of these two varieties. Invasion of glands is a little more rapid in a case of adenocarcinoma than of squamous-celled carcinoma of the cervix. The parametrium is rapidly invaded from the lymphatics; it may be hard and fix the uterus or still soft, but in either case must be considered as infected and treated accordingly. The progressive invasion soon involves the ureters and compresses them so that lesions of the kidneys are frequently associated with cancer of the cervix. Infection following, the course of the lymph vessels encroaches upon the bladder, and the rectum a little later. The peritoneum, nerves and appendages are involved much later. The vagina is invaded more or less rapidly, sooner in adenocarcinoma than in the squamous-celled variety. Propagation from the cervix to the body takes place either by the lymphatics or mucosa, or by metastasis. The lymphatics reach the uterus from above, and do not seem adapted for the extension of the infection from the cervix to the body of the uterus. There is a lateral anastomosis between the vessels of the cervix and body of the uterus with an ascending current; but, on the other hand, these may be obstructed by the growth which may so cause a reversal of the current in these lymphatics. Later on you will have an opportunity of seeing a series of microscopical preparations showing how a very remote part of the uterus can be infected in cancer of the cervix. (1) The first is a section of fundus in squamous-celled carcinoma of the cervix. You will note the invasion of tissue in the neighbourhood of blood-vessels. The subperitoneal vessels have lost their proper shape and show paralysis and thrombosis. This remote invasion is frequently seen macroscopically. The mucosa may be affected by ordinary inflammation,

but we rarely see extension of malignant disease along the mucosa. The operation of Schroeder must be rejected. It seems therefore that in every direction



NO. 1.—SECTION OF FUNDUS OF UTERUS IN CASE OF SQUAMOUS-CELLED CARCINOMA OF CERVIX.

the infection progresses by the lymphatics, and accordingly that the removal of the greater number of the glands becomes of the utmost importance. We do not suggest that every lymph gland of the pelvis must be cancerous in carcinoma of the cervix, but we believe that the pelvic lymphatic system is invaded by the infectious germ far beyond the limits visible to the naked eye. Many glands removed in the course of an abdominal hysterectomy for cancer have been found free from cancerous lesions on microscopical examination, but they are nevertheless the seat of those secondary infections which always accompany cancer. Moreover, and this is a very important point, many of the small, hard sclerotic lymph glands seem to be untouched by the disease, and yet show special characteristics which will be demonstrated to you, and which must attract your attention because here we find the explanation of the recurrences which take place as a general rule after all our operations.

The carcinomatous gland shows pseudo-glandular formations more or less ramified, sometimes with a distinct lumen, almost cystic, and lined by cylindrical epithelium. These lesions are met with in the peripheral zone in the neighbourhood of the capsule. The difference between the lesions of the lymph glands and those of the primary carcinoma comes from the fact that the evolution towards cancer is not completed; there are transition stages which will finally end in the typical cancerous lesion. This is the reason of the difference of opinion concerning the frequency of glandular invasion.

We are referring here to infection of pelvic lymph glands only, and do not attach much importance to inguinal adenopathy in cancer of the cervix. These glands have no connection with the cervix. The glands most frequently infected are those of the middle cord of the external iliac group situated at the point where the iliac vein is crossed by the ureter. In the invasion of glands there is no difference between adenocarcinoma and squamous-celled carcinoma. From a practical point of view, the lymphatic masses are most frequently met with when the parametrium is invaded. When the uterus is movable the glands are small, hard

and still sometimes very adherent to adjacent tissues: The study of the propagation of cancer to the lymphatic vessels and glands and its extension to more remote glands must make us admit that the term "recurrence," which we frequently use, is really nonsense. Cancer does not recur; it progresses and continues to invade, if not completely removed. The actual operative results seem to prove either that total ablation is impossible, or that our operations are imperfect. The recurrence after abdominal or vaginal hysterectomy is found nearly always in the vaginal scar. Certainly we always remove a large ring of the vaginal tissue, making our incision in what we consider to be normal tissue, but this amputation is really done at a venture, and must be inefficient, if it be done through cells invaded by the disease. We often see recurrence in lymph glands either alone or in the vaginal wall. In performing late secondary laparotomies we find always, even when the vaginal scar is free, that there are large pelvic glands which have produced intestinal adhesions and distant lymphatic metastasis. All these facts, which cannot, unfortunately, be further detailed, now lead us to the indisputable conclusion that carcinoma of the cervix is primarily a local infection originating in a *locus minoris resistentiæ* and spreading through lymphatic vessels.

These facts strengthen the new theories formulated by Doyen in a singular manner, to which we will now refer to for a few minutes. I expressed my opinions a few months ago when Doyen, of Paris, explained his treatment of cancer at the French Congress of Surgery, and I immediately began by controlling his experiment. He allowed me to try his serum and toxins on several of my own patients, and I now give the results which I have observed in cancer of the cervix. Of course, these are too recent to say much about recovery; but it is useful to verify these results from time to time, as in this way alone can the question be discussed scientifically. Allow me, therefore, to give you a few observations with full particulars: (1) In December, 1904, Dr. Mouvet of Yves Gomzee, sent to me a Mrs. X., æt. 38, who had had three children and no previous illness. She was found to be suffering from squamous-celled carcinoma of the cervix, which had invaded the left cul-de-sac and parametrium. There was a history of severe hæmorrhage, the patient was anæmic and thin, and had the characteristic colour of the face. The mobility of the uterus seemed to be sufficient to allow of total extirpation by the abdominal way, and I performed the operation on December 24th, 1904. The operation was difficult, as the bladder was adherent to the invaded parametrium and had to be separated; during this separation the bladder was torn, and it was instantly repaired. Thick masses of lymph glands were cut away from the parametrium on both sides, but it was impossible to perform complete ablation as the left ureter and parametrium were involved. The operation was finished as a complete hysterectomy, including a large ring of vaginal mucosa, but leaving a good deal of the parametrium on the left side. It was a very unsatisfactory operation, and did not leave any prospect of recovery. During the operation three tubes were inoculated with fragments from lymph glands, and all gave positive results within twenty-four hours. After the fourth day the patient was subjected to Doyen's injections, which were at first painful. A urinary fistula was present and her health was generally rather bad. Palpation revealed a hard mass on the left side. After the injections the fistula healed and the aspect changed completely. Later, the abdominal induration and pain disappeared. The patient received eighteen injections, and eat very well. She left the clinic at the beginning of February, the vagina being healed. Occasionally urine ran away during the night; nothing was to be noted in the parametrium, but a few small glands could be felt in the groin. Dr. Mouvet, who attends the patient, actually wrote on March 9th: "Mrs. X is getting on all right, her general health and aspect being good; she feels no inconvenience in the daytime, but she complains of vesical pain and tenesmus during

the night. These pains disappear when she stands or sits upright." I myself saw the patient on March 9th. Her general health was then very good indeed, but there was a small vesico-vaginal fistula, and the urine irritates the mucosa of the vagina. Nothing special was to be noted in the abdomen. In this case the improvement is really unexpected, and but for the operative accident, which caused the small fistula, I should consider this patient as actually cured. It is a real success if we look at the great extent of the lesions and the miserable health of the patient.

II.—*Inoperable Carcinoma of Cervix; Cachexia.*—In February last I saw, with Dr. Martin, a lady, æt. 38, suffering from squamous-celled carcinoma of the cervix and considered as inoperable by Dr. Rouffart. Her general health was miserable. The pain in the pelvis and lumbar region was so bad that her doctor was obliged to give her chloral, bromides in large doses, and two grains of morphine in the course of twenty-four hours. She had frequent uterine hæmorrhages, mucosa extremely pale, and there was extreme general weakness. The cervix was excavated, the tissues necrotic, and there was an ichorous discharge. The vaginal culs-de-sac were infiltrated and the ureters invaded. Posteriorly the vagina was adherent to the rectum. The uterus was completely fixed, the parametrium being less involved on the left than on the right side. This case was certainly desperate; there was nothing to be done. In this situation we had recourse to Doyen's injections. The first two injections were painless and produced no reaction. The third was followed by severe pains and fever (30° C.), with slight nettle-rash on legs. The pain continued for forty-eight hours, when a complete lull took place. The ichorous discharge diminished and lost its special smell. Locally, the vaginal wound looks more vivid. The amount of morphine was diminished to $\frac{1}{10}$ th of a grain, and the bromides and chloral omitted. The gastric and intestinal functions were regular. The fourth injection was followed by painful reaction, but this did not last so long. In eighteen days after the first injection the vaginal wound became smaller, there was scarcely any flooding, and the pain in body and loins had nearly vanished. The tenesmus after each action disappeared. Bimanual examination revealed a considerable change; the uterus was again movable, the hard mass on the right was still present, but seemed less diffuse and more limited, and the vaginal infiltration had diminished; the general health was satisfactory. The fifth and sixth injections were still less painful. The improvement was still continuing, when suddenly the periods came on in such a way that the patient became exhausted, and I decided to operate. The operation was performed on March 17th, 1905. I was able to remove the genitals and scoop out the left side of the parametrium. On the right side the cancerous masses involved the ureter and were untouched. I closed the peritoneum and drained through the vagina. Three tubes were inoculated with fragments of lymph glands, two gave a positive result. The patient recovered without incident. The injections were continued, the general health improved, and the parametric lesions are retreating.

III.—*Squamous-celled Carcinoma of Cervix.*—Mrs. Y., æt. 45, was sent to me by Dr. Meuldermans, of Chappelle-au-Bois. She was the mother of ten children, of whom the youngest was three years old. She had suffered for several months from carcinoma of the anterior lip of the cervix, the cul-de-sac being free. The usual local and general symptoms were present. Operation performed on March 2nd, consisted of abdominal hysterectomy, clearing out of the parametrium, and resection of the vaginal mucosa. No incident after operation. Actually the patient is literally transformed.

IV.—*Squamous-celled Carcinoma of the Cervix.*—Mrs. V., æt. 40, attended by Dr. Reh; had four children; last confinement ten months ago; suffering for four months with continual metrorrhagia; not much pain but bad general health. The cervix invaded

towards the left commissure and the left cul-de-sac largely involved. Uterus movable. The operation was performed on March 4th, 1905, and consisted of abdominal hysterectomy, clearing of the parametrium, and a large excision of vagina. Operation satisfactory; injections before and after operation; no reaction. General health good. Inoculation of tubes gave positive results. On April 1st, the patient looked very well.

V. Cancer of the Cervix.—Mrs. B., æt. 34, three children; came from Courcelles, sent by Dr. Carlier. Suffered for five months from a large carcinoma of the cervix with slight invasion of the cul-de-sac. Operated on February 22nd, 1905, by abdominal hysterectomy and resection of culs-de-sac. No incident after operation. Injections are regularly continued since. General health splendid.

Gentlemen, evidently I cannot draw any deduction from these few cases. They are, of course, too recent. In the future alone we will be able to say whether this new treatment has any influence on the recurrence or not. Nevertheless, I consider the first two cases were in the worse condition, and the first came back to health after two months; the second, completely inoperable and likely to die in a short time, was able to undergo an operation after one month of treatment, and is now in such a condition that I am convinced that anyhow I prolonged her life. These results induce me to explain in a few words the researches of Doyen on malignant new growths and their etiology.

Two points of equal importance have been set forth by Doyen:—

1. The existence in malignant growths of a micrococcus called by him "neoformans."

2. The resolvent action on malignant growths of liquids obtained by the culture of this micrococcus when introduced into the organism.

1 *M. Neoformans.*—Neoplasms progressing rapidly contain in their tissue a special micro-organism which can be detected in sections and by cultures. To verify its presence it is sufficient to sow in an appropriate broth, with all the necessary care, fragments of the growing part of a non-ulcerated tumour or, still better, fragments of infected lymph glands from the neighbourhood of the growth. The centres of big cancerous growths are almost sterile, the glands giving the best results are those recently infected and remote from the primary lesion. The best broth is obtained from the udder of the cow, with the addition of 1 per cent. peptone and sugar. After incubation of eighteen to twenty-four hours at earliest, or three to six days at latest, one sees the growth of the micrococcus which can be stained by special aniline dyes and be transplanted from this first culture to solid media. A peculiarity which strikes one immediately is the fact that the micrococcus does not start growing before eighteen to twenty-four hours, and sometimes does so after three, four, or five days. The broth remains perfectly clear for twenty-four to forty-eight hours, and then suddenly becomes turbid. If a tube grows thick during the first few hours it is infected by staphylococci or saprophytic bacteria. The *M. neoformans* does well by stab puncture in agar-agar containing 2 per cent. glucose. In broth, the culture is very similar to that of the streptococcus pyogenes. The broth becomes clear after three to four months incubation. The *M. neoformans* is small and appears under the form of a mobile diplococcus; sometimes three adhere together or form a short chain. The micrococci are often not more than half a micron in diameter. If we spread on a slide the scraping of a fresh tumour and stain with carbolic violet for twelve hours after fixation by absolute alcohol, the preparation will show the *M. neoformans*. A few retain Gram's stain. During the first few hours one notes the cocci and diplococci scarcely retain the Gram stain; after eighteen hours, when the culture becomes distinct, the cocci retain the stain better, and after twenty-four hours' incubation, the micrococci are very numerous and retain the Gram very well. In a culture of forty-eight hours, short little chains and groups of

different importance appear, the little chains are very often forked in the shape of the letter Y. When kept the culture loses the property of retaining the Gram and aniline dyes. In animals, inoculation provokes an intense inflammation followed by the formation of different neoplastic growths.

With the object of controlling the presence of the *M. neoformans* in the malignant growths on which we operated, we employed the technique indicated by Doyen, and these are the results we noted. In all, ten tumours were fertile:—

October, 1904.—Cancer of breast: One case brotth sown with lymph gland.

February, 1905.—Cancer of breast: One case, four tubes, one sterile.

January, 1905.—Cancer of breast: One case, lymph glands and fragments of tumours.

March, 1905.—Cancer of breast: One case, lymph glands and fragments of tumour.

Six cases of carcinoma of the cervix gave six positive results. Two cases did not show the existence of the *M. neoformans* by sowing fragments in the ordinary way. The first was a case of fibroma in a state of colloid degeneration, and the second a fibroma undergoing calcareous degeneration. These experiments seem to show the fact that the *M. neoformans* is almost always to be found in rapidly progressing tumours, particularly in the zone of progression and in the most recently invaded glands. We succeeded, too, in staining the *M. neoformans* in sections. The *M. neoformans* appears as a diplococcus or an isolated coccus, some of them retaining the Gram but the greater number lose the stain after the action of the iodine. The micro-organisms are then easily confounded with cellular granulations. Finally, we tried injections of living cultures into animals, but these experiments are too recent to speak of. From experiments multiplied during years, by the analysis of different growths which he provoked by inoculation of the *M. neoformans* on animals and by the analogies which exist between the tissues of the cancerous human body and those of animals subjected to experiment, Doyen has formed a new theory relative to the etiology and pathology of cancer. The essential character of cancer is to invade the tissues and lymphatic vessels and glands progressively. It starts from a localised focus, several foci are rarely seen at the same time. The cases of generalisation at first onset are the generalisations of an unobserved little focus, so that removal of such growths is followed by recurrence because infection exists far beyond the limits seen by the eye. Cancer should be an infectious disease. The formation of a tumour is nothing else than the expression of the defence of the organism against the pathogenic germ. According to the tissue it invades, connective tissue, epithelium, skin, the mucosa, glandular tissue, bone, proliferation starts as a process destructive to the infective agent. The infectious germ of cancer should specially excite the cells of the normal tissues of the organism whether of ectodermic or mesodermic origin. This cellular multiplication should play the *role* of phagocytes. The neoplastic process is always accompanied by the ordinary inflammatory processes with multiplication of the leucocytes. Doyen noted a very important fact that growths which did not give a culture of *M. neoformans* did not recur; others which gave positive results, recurred rapidly or generalised rapidly if not operated on. In the struggle between the normal cells of the body multiplying themselves to fight the invading foe, if this last one be victorious, we may see the transformation of a benign into a malignant growth. The theory of infection explains the possibility of the coincidence of carcinoma, sarcoma, epithelioma, and fibroma. It results from these observations that growths developed at the expense of the middle layer of the blastoderm do not provoke such rapid glandular infection as epithelial ones. This can be explained by the greater vitality of the cells of such origin which are better nourished than epithelium. To sum up, the infectious germ of carcinoma produces, at the point where it has penetrated and multiplied itself, a true

inflammation in the neighbouring cells. If the culture is not virulent the microbe is rapidly destroyed. If on the contrary the culture is virulent, the normal cells multiply instantly to limit the infected focus and to destroy it by phagocytosis. This destruction, however, does not stop the microbic multiplication, which takes place on the limits of the primary focus. Such are the general terms of the new theory which has but one defect, as Doyen himself says, and that is, to upset in a few lines everything which has been said up to the present concerning tumours.



NO. 2.—SPECIMEN SHOWING INVASION EXTENDING ALONG COURSE OF SMALL VESSELS.



NO. 3.—SPECIMEN SHOWING INVASION ALONG LARGER VESSELS VISIBLE MACROSCOPICALLY.

The introduction into the body of toxins produced in glycerinated broth provokes, particularly in infected glands, a reaction similar to that caused by tuberculins in persons suffering from consumption. Experiments carefully conducted during several years have caused Doyen to consider antineoplastic serotherapy as a curative treatment of cancer. He injects under the skin serum and toxins, but in rapidly progressing cases one ought to be very careful as the best results are obtained in cases of slow evolution. It is evident that the cure of rapidly generalised cancer cannot be hoped for, but if the results published by Doyen are confirmed the therapeutics of cancer will have made great progress, since it would be possible to stop, or at least to hinder, recurrence in the greater number of cases which should have been submitted to treatment before the destruction of organs essential to life. The serum and the toxins must be employed of different degrees of virulence, according to the anatomical variety of the growth and according to its evolution. The injection can be made at any part of the body. It provokes the immunisation of patients who are still able to react favourably. The first injections cause a rather strong general reaction, but the sedative effects follow quickly, and the subsequent injections produce slight reactions. The inflammation in the neighbourhood of the cancerous foci diminish rapidly, the tumours become movable, and their excision becomes possible. Continuation of the injections should lead to sterilisation of the soil, and prevent the recurrence, or slacken the evolution, of the growth. From these facts, and from the microscopical specimens I have shown, I may be allowed to conclude that the cancerous infection progresses along the lymphatic channels, the germ being, or not being, the micrococcus neoformans of Doyen; that we must operate in the interest of the patient and operate as soon and as widely as possible, and take the greatest care in clearing away the infected lymphatic system. By doing so we might perhaps prolong the existence of some patients and with the new treatment, as a complement to the operation, protect them against recurrence. The future only will show this, and in the meantime it is our duty to try and control the new treatment and its results.

ACUTE SUFFOCATIVE PULMONARY ŒDEMA.

By T. GILLMAN MOORHEAD, M.D., M.R.C.P.I.,
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THE following two cases, which occurred during the last few weeks under my care in the Royal City of Dublin Hospital, illustrate a condition which has not, I think, received the attention that it deserves. The name which I use to designate it is that which was employed by Professor Steven, of Glasgow, in a paper on the subject in the *Lancet* for January, 11th, 1902, and since then the same name has been applied to a similar but recurrent œdema of the lungs by H. M. Hewlett (*a*). As Steven points out, very little notice has been taken of these cases and in particular they appear to have escaped the attention of the text-book compiler. It is not even referred to in Sir Isambard Owen's "Clinical Lecture on Œdema of the Lungs," which appeared in the *British Medical Journal* for January 2nd, 1904, and in which he appears to only recognise the chronic variety. The following are brief notes of my cases:—

Case 1.—W. B., male, æt. 13, was first seen about two years ago as an out-patient. He was then suffering from chorea and had a well-marked systolic mitral murmur, the result of several previous attacks of acute rheumatism. He

(a) H. M. Hewlett, "Med. Journ." Australasia, December, 1903.

remained under my observation as an out-patient until November, 1904, when he was admitted to hospital and passed through a typical mild attack of enteric fever. He was discharged early in January, 1905, to a convalescent home, and returned to school on February 7th. On the day previous to this I had seen him, and found him then unusually well. On February 13th he played a game of football, contrary to orders, and felt rather ill that evening. In consequence he was brought to my dispensary on the following day, and was able to walk the distance to it of about a mile. On arrival he looked very ill, his pulse was feeble and frequent, and he had a slight cough. He was at once admitted, and examination revealed the presence of a slight pericardial rub over the base of the heart, in addition to the old systolic murmur. The pulse rate was 112 per minute. A few moist *râles* were also heard over the base of both lungs; respirations 48 per minute; T. 100° F.; urine normal. The patient remained quite easy and without complaining until 9 p.m. on that evening, at which hour his cough began to become more troublesome and he began to expectorate a frothy pinkish white fluid. During the next few hours his distress increased, and the expectoration became much more profuse so that I was sent for about 12.30 a.m. On my arrival half an hour later I found the boy sitting up in bed, slightly cyanosed, and breathing 60 to the minute, while a fluid, similar to that described above was literally pouring out of his mouth. The pulse was fairly good, 130 per minute, and the boy was able to answer a few questions addressed to him. Examination of his chest revealed the presence of loud moist *râles* all over both sides, but there was no dulness to be detected. The heart was beating strongly and the pericardial murmur could not be heard. Immediate and powerful stimulation with strychnine, digitalin, and, later, alcohol was employed, but all means proved useless and about 5 a.m. the patient died.

Post-mortem.—A complete autopsy was performed, and the following points of interest noted. The lungs were very voluminous and did not fall away from the front of the chest on opening the thorax. The pleural surface appeared red and slightly dulled, and microscopical examination revealed a very early stage of universal pleuritis. On cutting into the lungs a large quantity of typical blood-stained œdema fluid poured out, and a similar frothy fluid was found within the trachea and bronchi. About an ounce of turbid fluid was present in the pericardial cavity, and a little fresh fibrinous deposit on the anterior aspect of the heart. First vegetations were found on the edge of the mitral and aortic valves. The myocardium was microscopically normal.

Case II.—This case was, if anything, more rapid in its onset and course than Case I. The patient, a girl, æt. 11, was admitted to hospital on April 4th, 1905, complaining of pain in the chest and slight cough. The only history obtainable was that the child had had acute rheumatism on two previous occasions, the first time five years previously, and that she had suffered more or less from her heart since that time. On examination after admission, the typical signs of pericarditis with considerable effusion were found and a double mitral murmur was detected. The lungs were normal in every way. There was slight albuminuria and the chlorides were almost completely

absent from the urine. Pulse 132, respiration, 40, T. 101° F.

During the next week the effusion began to diminish rapidly and by April 12th had completely disappeared. The child at this date felt perfectly well, and could only with difficulty be kept quiet in bed. On the next morning some slight pain in the chest was complained of, but careful examination revealed nothing further than the double mitral murmur. The pulse, which on the previous day numbered 90, was now, however, 120 to the minute, lungs normal, urine free from albumen, chlorides still almost absent. The child remained fairly easy until 10.30 p.m. that night, and then quite suddenly began to cough. The house surgeon, Dr. Hallowes, examined her shortly afterwards, and found that she was coughing up enormous quantities of frothy fluid, and that loud moist *râles* were audible all over both lungs. He gave strychnine, digitalin and ether injections during the next couple of hours, but as these had no effect and as the symptoms were increasing, I was sent for about 1 a.m. On my arrival, however, the child was dead, in less than three hours from the onset of the first symptoms. Dr. Hallowes, who had seen Case I., described above, informs me that the symptoms in this case were identical with those in Case I., and that, during the last half hour of life, the fluid was pouring in almost a continuous stream out of the mouth. No autopsy could be obtained, but such I think was unnecessary as far as diagnosis was concerned.

In reporting these cases I do not wish to maintain that they are rare, but rather to impress the importance of being aware of the possibility of such an occurrence, and of being prepared to employ at the earliest possible moment free stimulation. It is not likely, indeed, that in such acute cases as those described anything would be of avail, but at any rate the gravity should be at once recognised and treatment not delayed. As already pointed out, the recognition accorded to the condition is but scanty, and about the best description is that given by Osler (a) in the following words: "The symptoms are often only an aggravation of those already existing and are due to the primary disease, whether cardiac, renal, or general. There are usually increasing dyspnoea and cough, and on examination there may be defective resonance and large liquid *râles* at the bases. There are cases in which the œdema comes on with great suddenness, and in chronic Bright's disease it may prove rapidly fatal." West (b) also devotes a paragraph to the "acute œdema," but hardly seems to insist sufficiently upon its possible gravity. On the other hand, no reference at all is made to it in Clifford Allbutt's System unless the condition be regarded as identical with the "active congestion of the lungs" of some authors. I am unable to find any reference pointing to any special connection between acute pericarditis and acute pulmonary œdema. Cheadle, (c) indeed, writing of the acute rheumatism of children, states that "occasionally endocarditis and pericarditis together with myocarditis run an acute course; delirium supervenes, respiratory distress becomes great," but this is obviously not identical with the cases I

(a) "Practice of Medicine," page 636.

(b) Samuel West, "Diseases of the Organs of Respiration," p. 243.

(c) Cheadle. Clifford Allbutt's "System of Medicine," Vol. III, page 45.

describe, nor can Sturges (a) "acute carditis" be regarded as identical with it. Possibly the condition may be included under the "acute cardiac failure" recognised by all writers as a possibility in pericarditis, but if so the term "cardiac failure" is being stretched to include a condition which does not present the usual symptoms of a cardiac death. In both my cases the symptoms appeared to be primarily pulmonary, and the absence of either extreme cyanosis or dilatation of veins pointed in the same direction; while the first autopsy confirmed this view, as it showed (1) an early stage of acute universal pleuritis; (2) a healthy myocardium; (3) no extreme distension of the right side of the heart. Again the only condition that I have seen at all comparable was a case of albuminous expectoration following the removal of a large pleural effusion. In such a case it will be admitted that the condition is primarily pulmonary, and yet the symptoms are almost identical except that they are as a rule unilateral.

TWO CASES OF WORD - BLINDNESS. (b)

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AND

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BOTH the examination of aphasic persons, and the analysis of the phenomena require special experience, and also a special mental aptitude on the part of the observer. The charm of the subject lies partly in the opportunities it offers for speculation on the brain as an organ of mind; thoroughly to understand the subject of aphasia would be a key to a great part of the mechanism of cerebral function.

(Before discussing the question of word-blindness, the connections and relation of the auditory, visual, and motor word centres, the graphic centre, and the ideational centres, as well as to Mills' chart indicating the general subdivisions of the concrete concept area were discussed.)

The fundamental speech centres are the auditory word-centres and Broca's convolution, the visual word-centre being a subordinate and entirely artificial product elaborated by education; it is no doubt a part of the cortex ordinarily devoted to the function of visual memory. It is developed only on the left side of the brain, probably, as Wyllie suggests, to facilitate training by concentration. In silent thought the counters commonly used are auditory word images, arrested by silent articulation in some persons. Visual word images take a foremost part in the recall of words, in only a very small number of persons, if, indeed, they can do so at all. From a consideration of our own mental processes, and the physiology of vision, we may conclude that the so-called "visuals"—persons in whom visual word images arouse thought—is very rare. It is said that such persons see pages of print rise before their eyes; it should, however, be remembered that in reading an ordinary book only one or two letters, or, at most, a syllable or two, can be seen at one

time distinctly, the rest of the page being blurred. It is impossible to imagine any one able to recall more than the image of one or two syllables at any one instant. If it were possible to do so, it would be quite easy to spell long words as rapidly backwards as forwards, which is notoriously not the case. The visual word and graphic centres are naturally closely related, and destruction of the former does away with the power of producing written language. When, however, word-blindness is unassociated with loss of the power of writing the lesion must be one which, while interrupting the paths of conduction from the visual centre to the visual word centre, leaves the latter itself and the facts connecting it with the graphic centre intact. In this connection Bastian's view must be remembered. In his opinion, in many "auditives" impulses pass directly from the word-hearing to the graphic centre without the intervention of the visual word centre at all. In such a case destruction of the visual word centre would leave the power of writing uninjured. Probably the visual image of the word plays a less important part in its being written than is generally believed.

Case I.—Male, æt. 61, had a "shock" two years ago, partially losing the power of the right arm and leg, but not of speech. He applied for advice, because he could not read, and was found to have right homonymous hemianopsia. Wernicke's sign could not be elicited; the pupils were equal and reacted well. On further examination he was found to be almost completely word-blind. He could name most of the numerals fairly correctly, and is able to calculate simple arithmetical sums fairly well. He used to read a great deal, and can now only spell out easy words with considerable labour. He can still write, although imperfectly. His name he writes with comparative facility, as also the word "Patterson," the explanation being that this was a name which used constantly to recur in his account books. Numbers he wrote to dictation with much greater facility. When asked to write spontaneously he always produced the following sentence without much effort:—"I want to see you to-night." He was not assisted in reading by tracing the letter over with his finger. There was no object-blindness.

Case II.—Male, æt. 63, right-handed. "Sight" had been affected for several months, but no precise history could be obtained. The patient was in hospital for cirrhotic Bright's disease and bronchitis, and was accidentally discovered to be suffering from right homonymous hemianopsia, which led to the investigation of his power of reading. His memory was bad, but he was intelligent; there was no weakness of the right hand, and no hemianæsthesia; he had formerly been a good reader and writer. His speech and hearing were good; he could understand spoken language, but could not name letters or words. He could write and spell spontaneously, but could not spell written words. He could read the numerals well, but could only copy writing or print by drawing the letters. The patient died, and on *post-mortem* examination, a lesion was found occupying the distribution of the left posterior cerebral artery. The points to be borne in mind in connection with this case were:—(1) Visual word-memories being stored in the angular gyrus, destruction of this centre affects the recognition of words; (2) in word-blindness, when the angular

(a) Sturges, Lumen Lectures, *l. ancer*, 1894, Vol. I.

(b) Read before the Edinburgh Medico-Chirurgical Society, May 3rd, 1905.

gyrus is destroyed, the centre for writing is thrown into abeyance, and writing is impossible; if the angular gyrus is spared writing is possible; (3) in pure word-blindness the lesion is a destruction of the connections between the occipital cortex and the angular gyrus, the latter itself being intact. In the case in question this was the lesion found, the whole of the right visual centre in the occipital lobe being destroyed, and also the fibres crossing from the opposite occipital lobe to the left angular gyrus.

ACUTE INTERSTITIAL KERATITIS

BROUGHT ON BY AN INJURY.

By KENNETH CAMPBELL, M.B., F.R.C.S.,
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INTERSTITIAL keratitis in congenital syphilis may develop almost at any age. I have seen it in a patient as early as two, and as late as forty years of age. It is, indeed, remarkable that the poison can remain in the system quiescent for years and suddenly light up into full blaze on a slight provocation. The following case is interesting not only on account of the interstitial keratitis being set up by a trivial accident, and being very rapid in its progress, but also for the reason that the patient wants to claim compensation under the Employers' Liability Act.

H. B., male, æt. 26, consulted me for trouble in the left eye. A few days previously a spark from the factory where he was working flew into this eye. The patient exhibited all the classical symptoms of congenital syphilis—stunted stature, lardy complexion, concave physiognomy, scars at corners of mouth, and Hutchinson's teeth. On examination, the left eye showed marked signs of interstitial keratitis, the cornea being cloudy from infiltration with leucocytes, and likewise presented the characteristic salmon-coloured patches. In addition, there was also irido-cyclitis with its accompanying phenomena of great pain and photophobia. On his first visit, the other eye was normal in all respects. On visiting me a fortnight after, however, this eye (*i.e.*, the right) also began to show decided symptoms of interstitial keratitis, which since has proceeded to involve almost the entire cornea. Had the disease remained localised to the one eye, it is possible that trauma alone might have accounted for it; but inasmuch as now both the eyes are involved, there can be no doubt whatever that the case is one of true interstitial keratitis of congenital syphilis. The patient is being treated with mercury internally, and the yellow oxide of mercury and atropine externally, and is making steady progress towards recovery.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON.
A MEETING HELD FRIDAY, MAY 12TH, 1905.

The President, DR. FREDERICK TAYLOR, being in the Chair.

A FATAL CASE OF TYPHOID FEVER WITH LOBAR PNEUMONIA DUE TO THE BACILLUS TYPHOSUS.

DR. SIDNEY PHILLIPS and MR. B. H. SPILSBURY recorded the case of a patient, æt. 20, who came under observation on December 2nd, 1904, suffering from typhoid fever at about the tenth day; the temperature was 105°6; the rash was just commencing to appear;

there were evidences of a patch of pneumonia at the right apex and of hepatisation of the whole of the lower lobe of the left lung. Four days later there were signs of resolution of the right apex pneumonia, but the patient's condition did not improve; the abdominal symptoms of the typhoid fever were moderate in severity, and tended in due course to decline, but the pneumonia at the base of the left lung showed no signs of resolution; the tubular breathing persisted and the fever, cyanosis and dyspnoea became extreme, toxæmia and failing pulse supervened and death occurred on December 11th. The necropsy showed numerous typhoid ulcers in the small intestines and a few small ulcers in the ascending colon; they were in various stages, but there was no perforation. The lower lobe of the left lung was in a state of red hepatisation throughout, and scattered throughout it were small white nodules which to the naked eye appeared to be tubercles. They were found by Mr. B. H. Spilsbury, in the pathological laboratory of St. Mary's Hospital, to be minute abscesses, in which were large masses of organisms; in some minute cocci retaining Gram's stain, in others bacilli, which had the morphological appearances and staining reactions of *B. typhosus*. The remainder of the lung showed the microscopical characters of delayed resolution of a croupous pneumonia. No pneumococci or tubercle bacilli were to be found in the lung. The lung and microscopic slides were exhibited at the meeting. Dr. Sidney Phillips in commenting upon the case, pointed out that pneumonia occurring in typhoid fever at any period in its course was almost always due to the pneumococcus or staphylococcus. Very few cases were on record where it was due, as in this case, to the specific bacillus of typhoid. Polguere, of Paris, had described a very similar case. In its clinical manifestations the case now recorded bore more the general characters of a case of pneumonia than of a case of typhoid fever, the pulmonary symptoms predominating over the general ones. The onset of pneumonia was early in the course of the typhoid attack, its development was rapid, and its resolution very much delayed; these were points which were said by Polguere to be characteristic of typho-pneumonia.

Dr. GOODALL remarked on the difficulty in conducting routine bacteriological examinations in the case of such a delicate bacillus as that of typhoid fever. As regards the diagnosis of pneumonia caused by this bacillus, the time of occurrence of the pneumonia might serve as an indication. Lobar pneumonia was not very common in typhoid fever, probably in under 3 per cent. of the cases, and was especially uncommon at the onset. Broncho-pneumonia, on the other hand, was common at the onset, especially in children, in whom it frequently simulated acute miliary tuberculosis. Ordinary lobar pneumonia was by far the commonest disease sent into hospital with the mistaken diagnosis of typhoid fever. He referred to the various unusual localisations of the typhoid bacillus in various organs, and asked Dr. Phillips whether he had any experience of such localisation in the lung apart from enteric lesions.

Dr. HERBERT FRENCH narrated four cases of three children and a mother who consecutively suffered from typhoid with pneumonic onset. The mother died. All were diagnosed as pneumonia to begin with. No bacteriological evidence was obtainable as to the lungs, but Widal's reaction was positive in all. He remarked that the leucocyte count was low in all, a remarkable feature in pneumonia, but common in typhoid.

Dr. HAWKINS said that lobar pneumonia only occurred in 1 per cent. of the cases of typhoid fever admitted to Middlesex Hospital.

Dr. PASTEUR agreed that acute pneumonia was not very common in typhoid fever. He speculated as to the frequency of the occurrence of the bacillus typhosus in the hypostatic pneumonia that was so common. He recalled a case of acute meningitis in which the bacilli were isolated *post-mortem* from the meninges; enteric lesions were present.

Dr. PHILLIPS, in reply, said that such cases as these of Dr. French were usually mixed infections. As to Dr. Pasteur's suggestion he remarked that Polguere examined bacteriologically an enormous number of lungs from cases of typhoid fever and in only one did he find the bacillus typhosus. The present case was the first one to be recorded in English literature. He had no knowledge of localisation entirely confined to the lung.

THE OPERATIVE TREATMENT OF CERTAIN CASES OF FRACTURE OF THE ASTRAGALUS.

Mr. HUGH LETT and Mr. J. HUTCHINSON, jun., read a paper on this subject. In certain cases of impacted fracture of the astragalus the foot remained in equinus combined with varus so that its functions were greatly impeded, the patient being unable to walk with the heel and toes touching the ground. Where manipulation under anaesthesia failed to correct the impaction (proved by the X-rays), the writers advocated excision of the fractured bone. At the same time they rejected the teaching of M. Ombredonne that all cases of fracture of the astragalus should be treated by excision, which can only be required in the exceptional instances of persistent deformity. It is suggested that in cases of dislocation of the astragalus the external malleolus should be chiselled through at its base to facilitate the reduction.

FRACTURES OF THE ASTRAGALUS AND OS CALCIS.

Mr. J. HUTCHINSON, jun., and Mr. LETT discussed a series of eight cases of fracture of the os calcis. The X-rays proving that comminuted fracture of the body of the bone was the most common form, due to falls from a height. Widening of the os calcis, a band of deep ecchymosis beneath the malleoli, and the appearance of flat foot were the chief signs apart from the conclusive evidence of the X-rays. Although several months usually elapsed before the patient could walk well the ultimate result, as proved by following the cases up after a year or two, was good. Hence operative interference in these cases was not indicated.

Mr. W. C. SPENCER, while admitting the great service skiagraphy had been in ensuring better diagnosis of fractures, pointed out that it had done harm in favouring the practice now prevalent of postponing immediate setting until a good skiagram could be taken. The importance of immediate setting of fractures before muscular rigidity appeared could not be overestimated.

Mr. HUTCHINSON, in reply, agreed as to the importance of early treatment and urged that operation should only be undertaken in the kind of cases under discussion when reduction by other means had failed.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.
MEETING HELD THURSDAY, MAY 3RD, 1905.

PROFESSOR JOHN CHIENE, President, in the Chair.

Dr. BYROM BRAMWELL showed (1) a case of Spleno-medullary Leukæmia treated by X-rays. The patient was a female, æt. 28, who had been admitted to hospital two months ago. The blood showed 540,000 leucocytes, of which 41 per cent. were myelocytes. Treatment with the X-rays was begun on February 28th, and was followed by a rise of temperature, which continued until the rays were intermitted. There had been gradual improvement, and now, after two months, the spleen which had formerly been enormous, was considerably diminished in size. The general health was better, and the leucocytes had fallen to 28,000; the percentage of myelocytes, however, remained practically the same—40 per cent. Dr. Bramwell also referred to a case of lymphatic leukæmia in a man, in which the same treatment had been carried out. The leucocytes at first numbered 350,000 per cmm., most of them being of the large lymphocyte type. The spleen and glands were enlarged. In this case, too, the rays caused inflammation over the spleen, and a rise of temperature, causing interruption of the treatment. The leucocytes fell to 8,000, but the excess of lymphocytes remained,

and there was a general improvement, though the spleen diminished in size. The red corpuscles did not rise, and the patient died. The treatment by X-rays in cases of leukæmia was not very hopeful, and should not be rashly undertaken. Serious inflammation in the region of the spleen might occur, and sudden death had been noted in some cases.

(2). A case of Chronic Gout, which was one of the most remarkable on record. The patient had been under the care of Sir Dyce Duckworth, upon whose advice he was admitted to Dr. Bramwell's ward. The man was æt. 52, and there was no history of exposure to any of the causes of gout—alcohol, excessive consumption of beef, or lead poisoning. His gout began in Australia twenty-eight year ago, and every year he had had several acute attacks. For eighteen years he had suffered from albuminuria. The remarkable feature of the case was the presence of enormous tophi, some as large as tangerine oranges, on many joints. Some of these had ulcerated and given rise to discharging sinuses. The hands were particularly affected, and there was also large tophi on the knees, elbows, and toes. Dr. Bramwell thought that surgical treatment of the uratic deposits was advisable.

Mr. J. M. COTTERILL showed a case of Multiple Chondroma and Chondrosarcoma. The patient was a male, æt. 40, who had suffered from numerous, and to a large extent symmetrical, chondromata since early life. Some of these had remained stationary for twenty years. On his back and attached to the ribs there was a large chondromatous mass about the size of a melon. Five months ago a rapidly growing sarcoma of the ilium had begun to appear: it was now of enormous size, and quite inoperable. Mr. Cotterill's experience of Coley's fluid having been unfavourable, he proposed to try the effects of X-rays in this case.

Mr. ALEXIS THOMSON showed a case of Extroversion of the Bladder, after transplantation of the ureters into the rectum according to Peters' method. The patient had a waddling gait, not unlike that of congenital dislocation of the hip, on account of the separation of the two rami of the pubes and absence of the pubic symphysis. The result of the operation had been most satisfactory as regards continence of urine: the boy could retain it for eight hours at night, and from four to six hours during the day. The urine always contained traces of fæcal matter, but there had never been the slightest sign of ascending infection of the kidney from the bowel.

Dr. W. STEWART showed a coloured Sketch of Feet from a case of Raynaud's Disease.

Mr. COTTERILL (1) A large prostate successfully removed by the suprapubic route. (2) Photographs of subastragaloid dislocation and unusual fracture of the femur.

Drs. J. V. PATERSON and EDWIN BRAMWELL read a communication on two cases of "Word-Blindness," which will be found on p. 507.

The paper was discussed by Dr. BYROM BRAMWELL, who remarked that carefully observed cases of word-blindness with *post-mortems* were few. In reference to the fact that one of the patients always tended to write the same sentence when asked to write spontaneously, he suggested that it would be worth investigating whether he had recently written the phrase at the time of the onset of the hemiplegia. An analogous condition occurred in motor aphasia.

Dr. THOMAS M. DEWAR read a communication entitled "A Plea for the Recognition of the Treatment of Disease by Intravenous Injection." To show the antiquity of the practice, he gave an historical account of the introduction of intravenous medication from the time of Harvey to the present day. Among more recent applications of this means of introducing drugs into the system were quinine in malaria, cacodylates in various diseases of the nervous system, mercury in syphilis, and formaldehyde in septic affections. Among the chief objections raised to intravenous injection were (1) that phlebitis, &c., might occur;

(2) that the proceeding was painful, and (3) that laboratory experiments on animals had failed to show that it was of benefit. On account of the fact that in phthisis a long series of injections was required, it was essential to carry out the treatment carefully, so as not to injure the veins. In his experience phlebitis very rarely occurred. Dr. Dewar then gave details of a remarkable case of septic infection in which, after antistreptococcus serum had been fruitlessly tried, striking improvement, and ultimately recovery followed on the intravenous injection of formaldehyde. He also referred to the advantage of giving large doses of anti-diphtheritic serum intravenously in cases of emergency. The chief part of the paper was devoted to a plea for the further use of his method of intravenous injection of iodoform emulsion in phthisis, and a discussion of the manner in which it acted.

The paper evoked a good deal of discussion, most of the speakers being unfavourable to the treatment.

Dr. SHAW described some experimental work he had carried out, and said that in the doses employed formaldehyde had no appreciable antiseptic action.

Dr. PHILIP and Dr. GULLAND had tried iodoform injections in phthisis without benefit. The latter also alluded to the feeble antiseptic power of the drug, and the fact that it was excreted very rapidly.

Dr. BURN MURDOCH was of opinion that it deserved a more extended trial in sanatoria.

LARYNGOLOGICAL SOCIETY OF LONDON.

At the meeting held on May 5th at the Society's rooms, under the presidency of Mr. CHARTERS SYMONDS, the following cases and specimens were shown:—
Dr. PINKUS, of Warsaw, in the absence of Dr. Herying, exhibited the workings of a new inhaler.

Sir FELIX SEMON showed an atomiser for the application of fluid vaseline to the mucous membrane.

Cases were shown by Dr. DONELAN, Mr. DE SANTI, and Mr. WAGGETT, the latter being a bleeding polypus of the septum in a boy.

Dr. LACK showed an interesting case of angioma of the palate, and

Dr. SCANES SPICER one of osteitis of the frontal bone.

The PRESIDENT showed a case of total extirpation of the larynx; and

Dr. H. J. DAVIS one of ulceration of the pharynx, associated with left facial paralysis in a man, æt. 47.

Dr. DUNDAS GRANT showed a case of ulcer of the pharynx which, in spite of its gummatous appearance, was considered to be epithelioma.

NORTH-EAST LONDON CLINICAL SOCIETY.

MEETING HELD THURSDAY, MAY 4TH, 1905.

Dr. R. MURRAY LESLIE, President, in the Chair.

Dr. J. W. HUNT read a paper entitled

PERSONAL ERRORS IN DIAGNOSIS AND TREATMENT.

The speaker thought that the older we grew the more mistakes we made, or perhaps it was that the older we grew we were less ashamed to confess our faults. At any rate, mistakes are not taken so seriously at the expense of the older as they were in the case of the younger. It had been said that if a young doctor lost a patient people were apt to remark, "What a bad doctor!" whereas if an older man were equally unfortunate, the fatal issue was ascribed to the severity of the disease. Happy were those who made the fewest mistakes. All made some. The commonest causes of error were ignorance, pure and simple; want of care, too great hurry, and physical or mental unfitness. The first was only excusable if a man had never had an opportunity of seeing a certain disease before, e.g., small-pox or typhus, otherwise it was culpable. Insufficient examination of a patient, from either the second or third causes, was a frequent source of failure to make a correct diagnosis, to wit, the neglect to examine the rectum or larynx in cases of obscure diarrhoea or hoarseness, respectively. Those who had to see a large number of hospital out-patients in

a comparatively short space of time were especially liable to be wrong in the "lightning diagnosis" they were often obliged to make. Sins of omission in this respect were often committed when mental worries or slight ailments prevented the physician from concentrating the whole of his faculties upon the elucidation of a case. On the other hand the treatment of a disease was often correct when the diagnosis was wrong, and *vice versa*.

Dr. F. J. TRESILIAN (Enfield) communicated a paper upon

THE VALUE OF ISOLATED SYMPTOMS IN THE DIAGNOSIS OF DISEASE.

The speaker referred to the incomplete symptomatology of certain diseases as being a frequent source of error in diagnosis. Was there really one pathognomonic sign of tabes dorsalis, or of cirrhosis of the liver? He was inclined to think not. Kernig's sign, which was supposed to be of such value in meningitis, he had seen after pneumonia. Bilateral exophthalmos probably did not exist apart from Grave's disease. Albuminuric retinitis he regarded as the best positive sign of Bright's disease, both from the point of view of diagnosis and also of prognosis. Certain other signs, such as tracheal tugging in aortic aneurysm, and Köplik's spots in measles, he considered as real and useful aids to diagnosis. He would lay stress upon the value of the so-called "strawberry-tongue" as an isolated sign of scarlet fever. In one case in which this condition was present alone he observed desquamation a few weeks afterwards. He rather questioned the fact that tubercle bacilli in the sputum necessarily implied the existence of pulmonary phthisis. He did not know of any other cause which would give rise to palatal paralysis in children except diphtheria.

The PRESIDENT, in discussing both papers, remarked that the age of the patient was an important factor in the diagnosis of posterior basic from tuberculous meningitis.

Dr. THOMAS RUSHBROOKE dissented from the view that the "strawberry-tongue" was a necessary accompaniment of scarlatina. He was in the habit of inquiring what the tongue was usually like in health in such cases. He had also seen considerable peeling occur after pneumonia and German measles. The appearance of Köplik's spots were not, in his opinion, reliable signs of ordinary measles.

Dr. R. E. FOOTI contended that medicine was not, and could never be, an exact science.

Dr. G. BASIL PRICE remarked that the Widal reaction was a most valuable clinical test in cases of typhoid fever, though it did not generally manifest itself until about the sixth or seventh day. It only very occasionally occurred in other diseases. He also referred to the difficulties encountered both in the diagnosis and treatment of fractures about the lower end of the radius.

Dr. ARTHUR E. GILES had met with many instances in which, after laparotomy had been performed, it was impossible to determine the exact conditions which prevailed within the abdomen. He considered that more mistakes were made from the habit of looking for one sign which was considered to be symptomatic than from any other cause. Practically, there was no such thing as a pathognomonic sign, if, indeed, he might make an exception in the case of the foetal heart-sounds. These, when surely heard, were an infallible sign of pregnancy. The path of safety, he felt sure, lay in avoiding so-called pathognomonic signs, and in taking the balance of proportion of all the symptoms present in any given case.

ULSTER MEDICAL SOCIETY.

SPECIAL MEETING HELD IN THE MEDICAL INSTITUTE, BELFAST, MAY 11TH.

The President, Dr. CALWELL, in the Chair.

Dr. SINGLETON DARLING (Lurgan) showed two cases of "Actinomyces," one a young and the other an old man, both agricultural labourers. He had hoped

to show a third, a youth of 17, but had not been able to bring him. All three cases were in the Lurgan Infirmary at the same time. In each case an abscess had been opened and the little yellow bodies in the pus had been noticed by Dr. Darling, and had suggested the presence of the disease, which had been confirmed in all three cases by Professor Symmers, in the Pathological Laboratory at Queen's College.

Dr. VICTOR FIELDEN read a short paper on the
PHARMACOLOGY AND THERAPEUTICS OF ICE.

The effect of ice had to be considered both internally and externally. There was a direct or superficial local effect seen first, and then a deep local or reflex effect. The former was seen in the application of ice to inflamed piles, where it cut short all the cardinal symptoms of inflammation. In such cases discomfort in its use contra-indicates it. It is probable that the contracted vessels may fail to carry off the products of inflammation, and then heat is indicated instead of cold, but it is necessary to be cautious in changing from one to the other, and let a little time elapse after the removal of an ice pack or compress before applying heat. The deep local or reflex effect of ice is seen in pneumonia, and is probably analogous to the action of counter-irritants, there being in both cases a reflex action from the vaso-motor centres. There is little doubt that ice applied to the skin causes an effect on the viscus supplied by nerves from the same segment of the cord. Other effects besides contraction of the vessels were rise of blood pressure and direct abstraction of heat. Dr. Fielden considered the question of the effect of cold on the inflammatory process, and believed that the weight of modern opinion was in favour of the belief that in pneumonia at any rate there is a direct beneficial effect from the ice.

Referring to the therapeutics of ice, he dealt with its internal and external use. The former was recommended in vomiting, and after operations on the stomach and throat. The external use might be as a compress, poultice, or ice bag. Such use was advised in head injuries, acute inflammations of the eye in their early stage, pneumonia, and to the face in small-pox. Its use was also most beneficial in local painful conditions, specially of the joints, testes, and hæmorrhoids.

No discussion could take place on this paper, as it had been arranged that at nine o'clock all other business should be adjourned, and the subject for which the meeting was specially summoned be considered.
viz. :—

THE DIRECT REPRESENTATION OF IRELAND ON THE GENERAL MEDICAL COUNCIL.

Dr. CECIL SHAW moved: "That this meeting is of opinion that the medical practitioners of Ireland should be represented on the General Medical Council by a provincial practitioner, and with a view to attaining this end we support the candidature of Dr. Leonard Kidd." As regarded the first part of this resolution, Dr. Shaw said they were practically agreed. Except a few men, who for personal reasons meant to vote for Sir William Thompson, they had all agreed that the time had come to alter the present state of affairs, when all seven Irish members of the General Medical Council were Dublin men. But if they really felt strongly on this point, it was no good to pass academic resolutions: they must have the courage of their convictions and act, and since the only chance of defeating the Dublin candidate lay in supporting Dr. Kidd early and heartily he moved this resolution.

Dr. DARLING (Lurgan), in seconding it, referred to the admirable work for the profession already done by Dr. Kidd. The motion was supported by Dr. St. George (Lisburn), Dr. McKisack, Professor Byers, Dr. McCaw, Dr. Robb, and others. Professor Lindsay said he was not prepared to commit himself to any candidate yet, but did not move any amendment, and on the motion being put to the vote it was passed unanimously.

Special Articles.

THE POSITION OF MEDICAL OFFICERS OF HEALTH.

The position of medical officers of health is now once more forming a subject of discussion in *The Times*. It has been revived with reference to the recent summary dismissal from their posts of Dr. F. S. Bond, of Chipping Sodbury Rural District, after thirty-two years' service; and of Dr. Stewart Norman, of Havant Rural District, after twenty-six years' service. It is complained that "the medical officer of health is an officer appointed *inter alia* to tax the rapacity of landlords, and expose the knavery of builders, to seize and carry off the tainted goods of shopkeepers; yet these builders, landlords and shopkeepers have absolute power over him, to strip the coat from his back and take the bread from his mouth." It is proposed as a remedy that a medical officer of health who devotes his whole time to the work of his office should in no case unless convicted of misconduct, be dismissed without the consent of the Local Government Board. It is precisely in the smaller districts where medical officers are engaged to devote only a portion of their time to the work of their office that a position of independence is most required; whilst it is quite evident that the proposed reform, although it might do some good could not give the officers in larger districts the security required. The Local Authority would still fix the amount of remuneration, and decide when an increase, earned by long service should be granted, and it is easy to see how uncomfortable the position of an uncompliant man might, under these circumstances, be made. And the fact must not be disguised that only inferior men, more or less failures in their profession, will accept the paltry pay offered in many localities. The poverty, and not the will of these men too often renders them compliant to the aims of the mean, ignorant and vulgar men whose servants they are. A man in this position may remonstrate in private when flagrant neglect of duty is displayed, but he knows it is as much as his place is worth to make any public protest, or to set himself in opposition to his employers. He knows very well that when an Authority is dominated by men of a certain type it is because there exists no public opinion to which appeal can be effectually made, and that such an appeal would lead sooner or later to loss of his position. It is only medical officers of health and the few who take an interest in public health problems who are aware in how many municipalities, and especially in the smaller towns, where tradesmen and owners of slum property dominate the Authority, the first necessities of sanitary administration are neglected. The model bye-laws of the Local Government Board are usually adopted in their entirety, but are enforced only in so far as they do not interfere with the interests of landlords; the sanitary inspectors' department is undermanned and unprovided with disinfecting and drain-testing apparatus, and slum dwellings abound, whilst in many places no provision of any kind is made for the isolation of infectious diseases, and the Food Adulteration Acts, in spite of the presence of grocers and milk dealers on the Council, are simply ignored. It is most remarkable that *The Times* should suggest that the ratepayers have no remedy for the abuses complained of. The ratepayers' remedy, and the only complete remedy, is to turn out inferior members of Authorities and replace them by men really imbued with public spirit, and incapable of sacrificing the welfare of their poorer fellow citizens in pursuit of selfish, mean and sordid ends. This remedy is in the hands of ratepayers. It is their fault and their shame that it is not applied. The great bulk of the public know little, and seem to care less, about local government; men of intellect and position refuse as a rule to take part in it, they do not offer themselves as candidates for local boards nor trouble themselves to put fit men on. The existing apathy

the lack of local patriotism, forms a danger to the nation. Democratic institutions cannot be worked unless the bulk of decent citizens take an interest in them. Rather than allow the present state of things to continue, it might be well to revert to bureaucracy, and place all sanitary administration in the hands of the Local Government Board. The proposed change in the status of medical officers of health would be a move in that direction; but by diminishing the responsibility of local authorities and encouraging the indifference of citizens, whose duty it is to guard the interests of the community to which they belong, it would probably do more harm than good to the cause of real reform and social progress.

THE MEDICAL VISIT TO PARIS.

[FROM OUR OWN CORRESPONDENT.]

THE return visit of English medical men to Paris has excited a good deal of interest, not only in medical circles, but also among the general public. In the space at my disposal I cannot do more than give a general outline of the reception, for the mere enumeration of detail would require a small volume of prose.

The delegation comprised some 200 practitioners, with Sir Wm. Broadbent at their head, but it included many eminent members of the profession, among others Sir Lauder Brunton, Mr. Mayo Robson, Dr. Pye-Smith, Dr. Clifford Allbutt, Mr. Arbuthnot Lane, Sir Dyce Duckworth, Dr. Murray, of Newcastle, Dr. Murrell, Dr. Beevor, Mr. Battle, Mr. Gould, Mr. W. MacEwen, Mr. Clement Lucas, &c., &c. They were met at the station by the members of the organising committee and directed to their destination. The same evening there was a reception at the Sorbonne, where speeches expressive of mutual esteem were delivered, and the visitors inscribed their names and collected invitations. Unfortunately the melting of a fuse deprived this spacious and interesting building of light for half an hour and the speech-making was proceeded with by candle-light.

On Thursday the serious business was inaugurated, parties going off in various directions to visit the hospitals and asylums. The visitors were received by the medical and surgical staff and were afforded every opportunity of studying the organisation of Paris hospitals in its technical aspects.

In the afternoon there was a grand reception at the School of Medicine. The professors attended in their gorgeous robes and the Dean of the Faculty, Dr. Debove, delivered a telling little speech, in which he dwelt upon the internationalism of science, which knew no war "that disgrace to humanity" (a phrase which, by-the-by, was significantly omitted in the daily papers of Paris), adding that their common efforts were directed to reducing the area of shadow in which they dwelt, and in diminishing, as far as they could, the sum total of human suffering.

The visitors were then invited to inspect the historically interesting features of the building, among other things the magnificent tapestries, presented by Louis XIV., that decorate the ceremonial hall.

The next step was to adjourn to the Hotel de Ville, a palatial structure replete with marble staircases, noble sculptures and other works of art. The visitors were received in the majestic *salles*, resplendent with electric lights that competed with the bright sun that shone through the windows. They were welcomed by M. Brousse, the Mayor of Paris, flanked by the Prefect of the Seine and the Prefect of Police, who, in suitable terms, expressed their pleasure at receiving the English doctors, and in thus contributing to the much-desired *rapprochement* between the two nations. A military band filled in the intervals and reinforced the attractions of a well-furnished buffet.

The last item was a formal reception by the Director

of the "Assistance Publique" at the head office in the Avenue Victoria. This is the body that controls the hospital system of Paris, the asylums for the aged and infirm, provides for the bringing-up of abandoned children, and, in general, for the whole charitable work of the metropolis. In the evening the visitors turned up in great numbers at the reception given at the Salle Washington by Professor Bouchard. This was of the nature of a *conversazione*, the French medical profession being largely represented.

On Friday, after the morning visits to the hospitals, laboratories and maternities, the visitors adjourned to Chantilly to inspect the magnificent bequest made by the late duke to the nation. They were cinematographed on their arrival and the photographs were projected on to a screen later on in the day at the automobile club.

The entertainment at the Automobile Club was of a particularly brilliant description. In the private theatre various prominent lights of the Parisian stage rendered chosen fragments of operas and plays, chorists sang old French songs, winding up with a delightful pastoral ballet in the style of the eighteenth century, than which it would be difficult to conceive anything more artistic and graceful. By common consent the only drawback was the fact that the plethoric programme, in spite of judicious excision, was not exhausted until long, very long, after midnight.

On Saturday the first item was the visit to the British Hertford Hospital, due to the munificence of the late Mr. Richard Wallace. It is situated in Lavallois-Perret, at some distance outside the fortifications. Of Gothic architecture and built of stone, it offers a safe refuge for the sick poor of British nationality. The visitors were received by the committee, and were shown over the building, which they could not but admire.

There was no time to spare to arrive in good time at the Institut Pasteur, whither all the visitors made a point of going. This lies quite in another part of Paris, in the Vaugirard quarter. The visitors were received by Dr. Roux, the Director, who formally welcomed them to the home of Pasteur. Then, having gone downstairs to the tomb of Pasteur, in the presence of the British Ambassador, Sir Francis Bertie and Lady Bertie, and Madame Pasteur, Dr. Kingston Fowler, as Dean of the Medical Faculty of the University of London, and speaking on behalf of the English profession, asked permission to place a wreath on the tomb of the great master whose discoveries had conferred untold benefits on suffering humanity. Pasteur, he declared, was "le medecin de la medicine," in that he pointed out the causes of disease and the means of preventing them and arresting their action. He was followed by Mr. Augustus Waller, who declared that when, in the fulness of time, posterity judged the achievements of the nineteenth century, Pasteur's discoveries would be more highly esteemed than either steam or electricity.

The visitors then passed respectfully before the tomb, and subsequently dispersed to inspect the various departments of research. We must not omit to refer to the Pasteur Hospital, an institution for the reception of infectious patients and their treatment by Pasteurian methods. It comprises 120 beds (not all of which are at present available). Each patient has a cubicle all to himself that can be rigorously isolated from the rest. These cubicles are built of glass and tiles with rounded angles, so that no dust can collect and the cleansing is done by washing—never by duster or broom. It represents the *ultima ihule* of hospital asepis.

The visit concluded with a monster banquet at the Grand Hotel, in which some 400 guests, English and French, took part, under the presidency of Professor Bouchard. To distribute this large number took a lot of time, and it was getting on for nine o'clock before the waiters entered on active service. The incident of the evening was the conferring of the decoration of the Legion of Honour on Sir Wm. Broadbent, who, on receiving the same, was cordially

embraced on both cheeks by Col. Lunny, the representative of the President of the Republic. The toast-list was long, but was agreeably diversified by music, vocal and instrumental, but it was only at a very late hour that the guests were free to retire.

The list of free excursions open to the visitors is an extensive one ranging from Evian and Geneva to Pau and Biarritz, a journey covering close upon 1,500 kilometres. By general consent our French confreres have "gone one better" over the London reception, magnificent though it was; and the question before us is, "what is the next step?"

Viewed as a whole, the attitude of the authorities, civil and medical, was characterised by the greatest cordiality, and on every available occasion flattering allusions were made to the *rapprochement* of the two nations.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BREILIN, May 14th, 1905.

At the Thirty-fourth Surgical Congress, held under the presidency of Prof. R. W. Krönlein, Hr. Bier of Bonn, introduced the subject of

STASIS HYPERÆMIA IN THE TREATMENT OF ACUTE INFLAMMATORY DISEASES.

The process was quite painless, and it frequently prevented the necessity for surgical interference, he had treated some cases by it in the Bergmann klinik. The cases were not the most suitable for such treatment, being those of mastitis and furuncle. For inflammation on the trunk he made use of an exhaust apparatus, which he showed. In cases of purulent mastitis the least painful treatment was by a suction ball after the milk had been drawn off by an exhauster. The exhaust apparatus was only applied five minutes at a time, and through a total of three-quarters of an hour in the day. In cases of abscess no large incisions were made, only small punctures under spray. No cicatrix was left on healing. If abscesses arose under the suction treatment they were opened by a small incision. The suction quickly relieved the pain. In the treatment of furuncles he used cupping glasses. If there was a scab it was first removed, only small incisions were made. Healing took place in five days. In the case of carbuncle also only small incisions were made; six cases of perforated carbuncle healed comparatively quickly. In the cases of carbuncle of the face only very small exhausters were used. In the axilla it was difficult to apply the exhauster. There he used small cupping glasses, the rims of which had been rubbed over with grease. He repeated that by this treatment nothing disagreeable or painful need be done. A case of lymphangitis on the forearm and the back of the hand had nearly disappeared after setting up stasis hyperæmia fourteen hours by the application of a bandage. After the putting on of the bandage acute œdema and increase of inflammation followed, but the pain did not increase. This was a wholesome reaction, as in the inflammation the speaker saw a curative effort of Nature against the local poison. The stasis was produced by an indiarubber bandage. It had to be most carefully watched and it required the attention of an expert. Medical men not accustomed to the process should not treat phlegmons in this way. The bandage should remain on from ten to twenty-two hours. In a case of inflammation of the hand, with blisters and redness up the arm, improvement took place in fourteen hours. If the skin was delicate a gauze bandage might be placed beneath the rubber one. A case of suppuration of the first and second phalanges of the middle finger was completely cured after ten days' treatment. In such suppurating inflammations he would not recommend the incision to be made over the joint, as recovery would be hindered by doing so. He also advised diligent movement of the joint to be made to prevent stiffening. A case of bullet-wound of the hand, five days old, was treated. Sanguineous pus escaped from the wound, in which streptococci were found. The bullet was extracted, and then

stasis hyperæmia was set up. Great improvement had now taken place.

Eighteen cases of mastitis were treated in this way, which recovered in about three weeks; 120 of furuncle which recovered in 5 days; 6 of carbuncle requiring some (?) weeks; 18 cases of inflammation of the mastoid of which 12 were absolutely cured; two cases of dachryocystitis were cured. He had never seen the slightest harm from the procedure in the hundreds of cases he had treated by it.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, May 14th, 1905.

RESECTION OF HIP-JOINT.

REINER gave the members of the "Aerzte Gesellschaft" a history of an operation which he conducted according to Lorenz's method on a purulent tuberculous hip-joint. This operation is conducted by first opening up and separating the whole of the soft parts with much industry and care from the diseased capsule and its contents. The incision is so arranged that the limbus of cartilage around the acetabulum is removed with the capsule, leaving the trochanter major in combination with the femur, while the whole of the disintegrated joints is removed *en masse*; by this method it is claimed that the joint can be removed *in toto* without being opened.

Mosetig-Moorhof praised the surgical effort to relieve coxitis. He has performed the operation frequently with the best results. He mentioned three cases on whom he had performed the radical operation, when sinovial and osseous destruction was so great that the Lorenz method could not be carried out. In these cases a temporary resection of the trochanter was carried out with ultimate success.

STABBING IN THE ARTERIA AXILLARIS.

Weiss, as a guest at the "Gesellschaft," related the history of a case of considerable interest to the members. The patient was stabbed in the left shoulder from behind two hours before admission to hospital, and had all the symptoms of an exhaustive anæmia, which was due, according to history, to the amount of blood he had lost from the wound. After careful examination the injury was diagnosed to be a wounding of the arteria circumflexa which may have extended to the arteria collateralis radialis. On the fourth day severe hæmorrhage recommenced which aroused a good deal of consternation among the attendants. The patient was immediately put under chloroform and the deltoid divided parallel with its fibres, when it was discovered to the surprise of all, that it was the axillary artery and not the circumflex, that had been wounded in two places. The length of the openings in the wall of the vessel were a centimetre each, the one lying above the other below the penetrating wound in the posterior side of the shoulder. The injured part of the vessel was eventually resected and the wound healed by first intention. Since the operation the pulse has ceased in the brachialis and in both of its terminal branches. The left hand is quite blue and cold when compared with the right. The principal point of interest in this case is the difficulty of diagnosis owing to the strange confusion in the wound.

FUNCTIONAL NEPHRITIC DIAGNOSIS.

Zuckerkanndl brought forward two specimens from Liechtenstern's patients to which Kapsammer took exception last week, and said that he had had one of the patients under his care, and that he had found changes in the urine. This gave rise to a good deal of acrimony last week on functional diagnosis of the kidneys, which was only aggravated by Zuckerkanndl coming forward with specimens to support Liechtenstern's views. Zuckerkanndl disputed Kapsammer's assertion that the smallest tumour in the kidneys produced functional changes, after giving the results of examinations time after time without any physical change; and although the second case was undoubtedly tuberculous the urine was perfectly clear—no albumin, and having a normal specific gravity.

Kapsammer said he did not object to the new method of examination *per se*, but that the general examination was not properly taken to be reliable as phloridizin taken alone is no test.

Schüller thought that Kapsammer was now taking refuge behind the phloridizin test which Israel proved to the satisfaction of this Society in 1903 to be of great value in the diagnosis of disease in the kidneys, as the two organs do not secrete with the same constancy nor have they always similar constituents, therefore the catheterisation of the ureters will frequently give different results.

Liechtenstern said that bilateral ureter-catheterisation always gave a hæmorrhagic product which could be detected microscopically, and often macroscopically, which could not be avoided in the manipulation with the tender mucous membrane.

Kapsammer said that he acknowledged the surgical necessity of the kidneys but we must confess that many irregularities and difficulties arise in the diagnosis. Palttauf criticised the pathological anatomy and discordance in clinical results. He was in sympathy with many of the speakers who had formed their opinions from the limited number of cases, but it must be admitted that with all our novelties in diagnosis peculiar phenomena arise that lead to error. He then related a case that had recently come under his care with purulent left side nephritis, and where the right kidney was absent, that could lead to no error; the urine was found to be perfectly clear without the slightest change in any of its constituents.

Zemman at this point gave a pathological account of the cases leading to the present discussion.

Continental Health Resorts.

[FROM OUR SPECIAL CORRESPONDENT.]

AIX-LA-CHAPELLE.—(AACHEN.)

AIX-LA-CHAPELLE has many unquestionable claims to favourable attention: because of its readiness of access from our shores, of the great superiority of its medicinal springs, of the "latest" and scientific completeness of its therapeutic appliances, and of its unrivalled douche massage treatment. To these peculiar advantages may be added the healthfulness of its climate (the mildest winter climate of Germany), the skill of its resident physicians (thoroughly conversant with the qualities of its waters), the excellence and variety of its hotels, and the picturesqueness of its well-wooded suburbs.

To antiquarians and lovers of the past it also appeals strongly. As elsewhere, wherever the Roman Empire extended, we find here remains testifying that those "Masters of the World" largely utilised these Aachen springs; as was shown in the massive foundations laid open at the reconstruction of "La Reine de Hongrie" baths. The barbarian deluges devastated and demolished the place; but under the Carolingian monarchs it revived and speedily assumed splendour. Pepin sometimes resided here; and Charlemagne made it the metropolis of his wide-spread dominions. He re-established the Roman baths; and built a most interesting cathedral, in which thirty-two kings and twelve Queens of Germany were enthroned; the last of this long regal series being Ferdinand I., who in 1531 was here crowned with the silver diadem of Charlemagne.

No one can approach the venerable *Dom* without being impressed by its remarkable appearance and singular construction. The diversities of architecture existing in the different portions of the great building excite curiosity. The grand octagonal tower, rising with unique majesty in the midst of the various additions, is the sole survival of the Charlemagne building. The choir is a gem of fourteenth century Gothic; the chapel of St. Mathieu, containing the sacristy, dates from 1390; the chapels of St. Anne and St. Charles are 15th century work; and the Hungarian Chapel, in which are now kept the celebrated artistic objects of the Middle Ages, was constructed in the 18th century.

Among these priceless objects are the bones of the Great Emperor; his hunting knife, and an enormous ivory hunting-horn. Charlemagne donated to the cathedral relics which he had received from Oriental monarchs; the swaddling clothes and sheet of Christ—the robe of the Virgin, the linen used at St. John's Martyrdom, &c. These relics for many centuries past have been exhibited from the Cathedral tower every seventh year to tens of thousands of pilgrims.

Charlemagne was induced, so we are told by historians of his epoch, to select this city for his capital and favourite residence, because of the benefits he here received from its hot mineral springs. These springs flow freely from two distinct strata of upper Devonian limestone and run through the town in parallel courses from S.W. to N.E. Their output varies from 1,100,000 to 1,320,000 gallons every twenty-four hours; a quantity much in excess of any bathing requirements. Their temperatures vary from 38° to 77° Centigrade; the latter being found at the spring of the Schwertbad. This is the hottest spring in Central Europe; exceeding that of the Sprudel at Carlsbad. It is a favourite diversion of visitors to cook eggs in this naturally hot water, which can be done "hard" in less than 5 minutes, and proves more vividly than figures to the "man-in-the-street" the heat of the spring.

Operating Theatres.

GREAT NORTHERN HOSPITAL.

OPERATION FOR SUPPURATIVE APPENDICITIS.—

Mr. PEYTON BEALE operated on a woman, æt. about 30, who was admitted with a large hard tumour in the right flank, accompanied by a temperature of 104°, whose history was as follows:—She had been confined three weeks previously, and there had been no complications, with the exception of the child being still-born. Seven days prior to admission she noticed some pain in the right lumbar region, which was accompanied by diarrhoea; she complained also of pain in the region of the spleen, but this was quite transient. The lumbar pain continued for a few days and became much diminished in severity; then a swelling appeared in the region of the right kidney, and she had a slight temperature. The swelling gradually increased and the temperature steadily rose up to the time of her admission. Her condition then was as follows: Temperature, 103.4°; pulse and breathing, both rapid; profuse sweating; aspect pale and distressed; a tumour in the right side of the abdomen, about as large as an adult head, freely movable, tender only when pressed in the lumbar region, apparently solid, and in all respects exactly like a very large right kidney, except perhaps for the fact that it extended rather anteriorly; there was slight œdema of the skin over the lower part of the tumour. Considering the temperature, the aspect of the patient, the history of the recent confinement, and the absence of all abnormality in the passage of the urine and of the urine itself, it was thought probable that the case was one of an abscess in connection with the broad ligament or Fallopian tube, spreading up to and involving the liver, leading to a condition of pylophlebitis. It was deemed advisable to open it without delay. It may be mentioned that the diagnosis of a very large and tense appendix abscess was duly considered, but from the position of the tumour and the absence of anything at all approaching the symptoms of appendicitis, an abscess due to that cause was deemed to be quite unlikely. The patient having been prepared, a four-inch incision was made exactly as for lumbar colotomy, but one inch anteriorly; the muscles having been divided, a very large abscess cavity containing over a pint of

exceedingly foul pus was opened. On exploring the interior, it was found to be completely shut off from the general peritoneal cavity and its walls were exceedingly thick. On exploring with the finger, what was believed to be the appendix could easily be felt on the upper wall. The cavity was washed out with 1 in 20 lysoform, a gauze drain inserted and the muscles sutured together for two inches, and the wound dressed in the ordinary way. Mr. Beale said that in considering this case it was quite impossible logically to believe that it was an appendix abscess; whatever the tumour might be, it was practically clear that it contained pus and that the pus was at considerable tension, the patient exhibiting all the symptoms of septic absorption; hence the decision to operate at once. So many of these cases which were difficult to diagnose turned out to be appendix abscesses that he invariably employed the lumbar incision, because by so doing he was certain of reaching the pus without passing through the peritoneal cavity and also without the risk of opening it: he had advocated this incision in such cases for a long time, not only for the above reason, but also because it afforded perfect drainage it was not so liable to give rise to hernia when healed, and any subsequent operation for the removal of the appendix or its remains was rendered much more simple than would be the case if it were necessary to operate through or close to a pre-existing scar. In all cases like the one he had just operated on he strongly deprecated any attempt to remove or even search for the diseased appendix at the time of opening the abscess; even if it were exposed to view, it was much better, he said, to leave it alone and deal with it, if necessary, some weeks after all acute symptoms had passed away.

CANCER HOSPITAL.

REMOVAL OF THE APPENDIX AND OVARY.—MR. BOWREMAN JESSETT operated on a woman, *æt.* 34, who had been suffering for a considerable time from severe pain in the right iliac region. She had been into one or two hospitals previously, being treated medically without benefit. On admission to the Cancer Hospital, when examined the abdomen was flat, with slight fullness over the right iliac region and a very distinct tenderness over McBurney's spot on deep pressure; there was no pain or tenderness on the left side. She said she had had discharge like pus from the vagina, also a quantity from the rectum of like matter, and "pieces of flesh," and she complained of pain in the right iliac fossa and hip externally down to the knee. When sitting she had pain in the hip-joint of the same side. Her periods were quite regular, but the pain was accelerated at these times; she had suffered from sickness and indigestion. *Per vaginam* the uterus was found mobile and healthy with some fullness and tenderness of the right fornix. Bimanually, a distinct resistance apparently in the right iliac fossa was felt. The following operation was performed: an oblique incision was made midway between the umbilicus and the right iliac spine extending through the rectus muscle; the abdomen being opened, and the cæcum withdrawn through the wound, the appendix was found thickened and enlarged extending downwards into the pelvis. On following this down it was found to be adherent to the right ovary, which was enlarged and cystic. Mr. Jessett first removed the appendix in the following manner: a catgut ligature was passed through the mesentery, which was firmly ligatured; the appendix was then detached from its mesentery quite up to its origin at the cæcum; a strong pair of

pressure forceps was applied across the appendix, close to the cæcum and the parts crushed; a very fine silk ligature was firmly applied to the appendix at the crushed portion and the organ removed. The small piece of mucous membrane was removed from the divided end and the surface thus denuded washed with a drop of pure carbolic acid. A purse-string suture of catgut was inserted around the base of the cæcum some half-an-inch away; the ligatured stump was then pressed into the cæcum and the purse-string suture drawn taut, thus burying completely the divided stump. The right ovary and tube were next drawn out and removed in the usual way. The wound was closed by first uniting the peritoneum with a catgut suture, three or four silkworm gut sutures were then passed through the skin, muscle, and aponeuroses, about an-inch-and-a-half apart; the aponeurosis covering the rectus was then united with a continuous suture of catgut; the silkworm gut sutures were then tied, and a continuous suture of fine silk united the skin to its whole extent. On examination of the appendix the mucous membrane was found much thickened, with some pus and focal matter in it. The ovary was cystic and generally diseased. Mr. Jessett said that a good deal of controversy had of late taken place as to the best method of treating the stump of the appendix. He always contended that the simplest method of dealing with any part was the best, and by experiment in the *post-mortem* room, as he had often previously observed, he found that a ligature when applied firmly round the appendix invariably divided the mucous membrane completely, in the same way as a ligature applied to an artery divided the inner coat of the vessel; his practice therefore, had always been to ligature the appendix close to the cæcum without any attempt of reflecting a peritoneal flap as some surgeons advocated. The great object of the ligature of the appendix was to bury the stump, and this undoubtedly he thought was most easily and readily done by applying a purse-string suture passing through the serous and muscular coats of the cæcum as he had just done. In removing the ovaries and tubes he always made a point, he stated, of covering in the ovarian stump with peritoneum. He pointed out that in closing the parietal wound he adopted the plan of suturing the peritoneum first with catgut and the superficial aponeurosis with the same material, but he employed the method of passing silk-worm gut sutures through the skin, aponeuroses and muscle and ligaturing the same, as he had found in some instances that, by merely utilising buried sutures to unite the different structures, such firm union was not obtained as by the method he had just employed. The patient made a good recovery.

Conjoint Examinations in Ireland.

THE following candidates have passed the Diploma of Public Health Examination as undernoted:—John W. Dickson, L.R.C.P. & S.Edin.; Joseph J. Harrison Holt, M.B.; Joseph M. S. Kenny, M.B.R.U.I.; and Major Charles W. Reilly, R.A.M.C..

Royal College of Surgeons, Ireland.

A MEETING of the Fellows will be held on Saturday, June 3rd, at 10 o'clock, to receive the annual report of the Council. A meeting will also be held on Monday, June 5th, at 10 o'clock, pursuant to the provisions of the Charters, to elect a president, vice-president, council, and secretary of the college for the ensuing year. Fellows who may desire to have their names printed on the List of Candidates for Office will please signify their wish by letter, to the Registrar, at the College, on or before Tuesday, May 23rd.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, MAY 17, 1905.

THE KING EDWARD'S FUND AND THE QUEEN'S JUBILEE HOSPITAL.

THE recent inquiry conducted by the King Edward's Fund into the management of the Queen's Jubilee Hospital has resulted in a Report containing recommendations of a nature so unusual as to demand careful consideration. Although the hospital is comparatively small, yet the principles involved are of crucial interest to the charitable public, to the hospital funds, and to the medical profession. It is a matter for regret that no medical man sat on the board of inquiry. Such an omission must be fatal to any chance of the board of inquiry grasping many technical matters that can be adequately dealt with only by members of the medical profession. At the outset it may be stated as a highly satisfactory circumstance that no breath of suspicion has been cast upon the financial management of the hospital. Indeed, that fact has for years past been amply guaranteed by the grants awarded to the Queen's Jubilee Hospital by the Metropolitan Saturday and Sunday Funds, as well as by at least two substantial grants made to the building extension by the King Edward's Fund. That being so it follows that the finding of the Committee that before the appointment of the new medical staff the management of the Institution was "slack and unsatisfactory" can refer simply and solely to details of administration and organisation. The public will be relieved to find that this is a question not of want of honesty but rather, in the opinion of the King Edward's Fund, of want of method among those answerable for the Queen's Jubilee Hospital. The ground being thus cleared, there need surely be little difficulty in arriving at some reasonable compromise between the Fund which advises and the hospital, which, after all, is master in its own house. The Commissioners recommend the resignation of the Board of Management and of the newly-appointed Honorary Staff.

We confess that we are unable to understand how proposals of such a sweeping and, indeed, startling nature can be justified by anything contained in the Report, the Commissioners, strange to say, do not in any way condemn the action of the new medical staff in accepting their appointments. They further advise the resignation of the Board of Management and the appointment of a new executive by the Fund. At this point we may express our astonishment that any board of inquiry, especially one containing a legal member, could advance propositions of so irregular and illegal a nature. The King Edward's Fund is a distributing agency, and has absolutely no *locus standi* in taking over the management of any particular institution. Supposing such a hospital in their hands, would not the excluded hospitals at once rise in arms on all sides? The property of a hospital, again, not to mention its control, is vested ultimately in its governors, and it would be impossible for any executive to hand over the fortunes, and, for that matter, the very existence of its corporate entity to a self-constituted outside authority. As a matter of fact, the Report is riddled with various fallacies, contradictions, and unsupported conclusions. It is expressly implied, for instance, that no hospital is needed in the district where the Queen's Jubilee Hospital is situated. Yet no longer ago than December 22nd, 1903, the Chairman of the King's Fund, Sir Savile Crossley, inclosing a cheque of £200 on behalf of the Fund, wrote:—"I am also desired to inform you that my Committee consider a new hospital is urgently required in your district." A year later, on December 1st, 1904, one of the Commissioners, Mr. J. Danvers Power, actually wrote to the secretary, saying:—"We are glad to hear the building operations are now in progress at your hospital, and I will take care that this is reported to the Executive Committee at their next meeting." What has happened to cause such a right-about-face in Mr. Danvers Power's views? Certainly, nothing published in the Report can account for the change. Indeed, the whole document appears to be framed in obedience to a foregone conclusion. If the King Edward's Fund wish to escape from an indefensible position they will be wise in accepting the compromise held out by the Board of Management of the Queen's Jubilee Hospital. The reply of the latter is a most conciliatory and temperate effort to meet demands that could not be accepted as they stand by any body of self-respecting men. They propose that the constitution of the hospital be suspended for twelve months, that the present medical staff be retained, that the present Board of Management resign and be replaced by a temporary board for twelve months, half of the members of the latter to be appointed by the Fund, and the other half by the hospital. The Chairman is also to be appointed by the Fund. The Executive of the Queen's Jubilee Hospital, it will be remembered, courted inquiry in the first instance. They challenged then, as they challenge, still any im-

putation as to their absolute candour and *bona fides*. A similar spirit is now evinced in the ample olive branch now held out to the King Edward Fund. It is earnestly to be hoped that the latter will show no less a desire to arrive at a full and reasonable compromise. If they fail to do so now their attitude will drift from one of public policy into another little distinguishable from fatuous persecution. In any case we fail to see what right the King Edward's or any other hospital trust fund, can have to change their function arbitrarily from that of distributors of public trust money to that of trustees and executors of a voluntary medical charity.

THE IRISH MEDICAL ASSOCIATION AND ITS CRITICS.

At the commencement of this year, we stated very clearly in an opening article the attitude which we intended to adopt towards the Irish Medical Association. We stated that we desired to lend the Association all the support in our power, and to endeavour to further in every way its objects, so long as its efforts were directed towards the improvement and for the good of the medical profession. We further stated that, if at any time the Association should really or apparently depart from the principles which should govern every such association, we should criticise its actions fearlessly. Our reasons for making the latter statement must be plain to all. At the time we wrote, the Association was apparently cleft in two. As a body, it had adopted a definite policy, and one which had promised well for the future. This policy—we refer, of course, to the Enniskillen programme—met with the approval of the large body of members of the Association, but, without warning, the executive officers of the Association lent their support to an opposite policy, and the official organ of the Association did likewise. It was obvious that an Association could not prosper which held divided opinions on a vital point, especially when a minority was allowed to promulgate officially doctrines entirely opposed to those sanctioned by the Association as a whole. Furthermore, the appearance of the now notorious "Irish Medical Directory" had been foreshadowed, and, as it appeared that the Association in a moment of haste or of weakness had given its sanction to a scheme of professional boycotting, it was very necessary that there should be some impartial opinion to point out the vital error—to say the least—which underlay such a scheme. Lastly, we knew that, through no fault of the Association, but owing to the need for revision in its constitution, the control of the Association had passed into the hands of a too limited and insufficiently representative Committee; and that, though this Committee generously devoted a vast amount of time and labour to the business of the Association, it was, from the error of its constitution, unable to enforce discipline within the Association—a fact to which the columns of the *Journal* bore eloquent testimony. It therefore

was obvious, not alone to us, but to many of the leading members of the Association, that, if reform was to be effected, there would be abundant need for friendly and candid criticism of the present management of the Association. This belief has been amply justified. Since January last, the question of the Enniskillen programme has practically fallen into oblivion, and with it the immediate hope of financial betterment. In its stead, we have had endless heartburnings and bickerings over the "Evatt Report," and now the Association is further confronted with the fact that the responsibility for a so-called "Directory" has been foisted upon it, and that its official organ has boldly preached a campaign of boycotting in order to force every medical man to join the Association. In other words, the Association within a few months and without its knowledge, has been made responsible for a wholesale attack on all things and persons medical in Ireland, and for a work and a policy which are opposed to medical etiquette and professional morality. Against all this we have strenuously protested, and shall continue to protest until a remedy is found. It has been stated by a recent correspondent that our criticism is "palpably captious," and that it is directed towards the destruction and not towards the improvement of the Association. We do not think that it is necessary to deny such a charge, but the fact that it has been made shows to what lengths men who desire to force "a plan of campaign" on the Association are prepared to go. Recently, we have been obliged to criticise as acts of the Association matters which we knew had never been approved by the Association, because they have been boldly brought forward in the *Journal* as an official programme. At the same time, we have made it plain that the Association, though legally responsible for the acts of its officers, had never directly or indirectly given them its sanction. Is it necessary that we should define our position once more? Our desire is to see the Irish Medical Association properly organised, governed by a representative body of men, and so controlled that it shall be impossible for any member of the Association official or otherwise, to make the Association responsible for acts or policies other than those regularly and authoritatively adopted; to see it established as the representative Medical Association of Ireland on the firm basis of mutual support, and well clear of the quicksands of religious and political bias; to know that its every action will be governed by the dictates of professional morality, and will be such as can be accepted by the members of an honourable profession; and then to see it successfully work out the salvation of the Poor-law Medical Service, and the numerous difficult problems connected with the practical working of sanitation and medical practice in Ireland. While the Association regenerates itself, and after it has been re-established as an influential and capable body, we desire to assist it and to further its objects in every way.

THE HYGIENE OF TRAVEL.

IN the growth of modern hygiene it is curious how some branches have been almost entirely overlooked, while others have been developed with the most persistent care. We have paid scrupulous attention in theory if not in practice to many of the details of our daily life, while in regard to others we have been peculiarly careless. The necessity for careful supervision of our food supply, for the proper sanitation of our houses and towns, and for the hygiene of our persons has been perhaps sufficiently insisted on, although the advice has not been followed out. It is not long, indeed, since we commented on some of the dangers to the public which rise from modern conditions of railway travelling. It is not uncommon for a patient in early but still unsuspected typhoid fever to make a railway journey, and as he goes he scatters typhoid bacteria along the open railway line, whence in dust, as in water, they may very soon find their way into a food or water supply. Up to the present, we know of no form of water-closet provided in trains to prevent this serious danger. A matter of importance to the travelling public is the cleanliness of the carriages in which they have to travel. Unfortunately, of this we have practically no guarantee, as the methods ordinarily used for cleaning carriages, even if used with sufficient frequency, are not such as to ensure confidence against the presence of the germs of disease. In the States, where much longer journeys are performed than in these countries, the Surgeon-General of the Public Health Service in his last Report (1904) calls attention to this subject, and suggests the use in railway carriages, of plain, smooth, surfaces such as may be readily cleaned. This would undoubtedly be an improvement on the present conditions, but while the apathy of the public toward the question persists, the railway companies are not likely to move. An equally important point is that blankets in sleeping-cars and cross-Channel steamers should be properly protected from soiling by being provided with slip covers of some washing material. With the present system, there is no protection against the carriage of not merely the contagion of disease but even of live vermin, and the appearance of a blanket as one often sees it in a steamer is suggestive of very unpleasant possibilities. While we have no desire to raise an alarmist cry about the dangers of travelling, yet we have no hesitation in saying that the present conditions are in many cases not merely dangerous to the public health but revolting to public decency.

Notes on Current Topics.

Exchange Loaves.

THE old custom of exchanging stale bread for new, hitherto prevalent in the baking trade, is in danger of becoming abolished, if it can really be proved that the practice of so doing is dangerous

to the health of the community. The Medical Officer of Health of Leyton, in a report upon the subject, has declared that the habit is distinctly risky, especially in poor districts, where the loaves are rarely covered up, but lie about anywhere, collecting dust with, of course, its contained germs. In one instance that came to his knowledge, bread which had been delivered on Saturday was returned on Monday from a house in which typhoid fever existed. Such cases as this, which occur, probably, with far greater frequency than those which can be traced, are not re-assuring, nor do they reflect credit upon modern sanitary science. It may be urged, in defence of the practice, that the presence of dust upon the stale loaves does not signify much, seeing that they are heated up again, but the danger lies in the handling of them during the interval. A little more foresight on the part of heads of households in calculating the quantity of bread consumed would prevent much trouble, but as few persons appear to possess this particular ecumenical quality, the London Master Bakers' Protection Society are endeavouring to obtain the support of the various medical officers of health with a view of stopping the practice of exchanging stale bread. As it is, the transit of loaves from the baker's oven to the consumer's table is open to considerable risk, hardly less than that of milk. The interior of baker's delivery hand-carts should be as much open to inspection as cow-sheds and dairies, for the traditional green-baize covering of the loaves rivals the linings, of milk cans, as far as the capacity for retaining germs is concerned.

More Uses For Diphtheria Antitoxin.

IN a recent issue of THE MEDICAL PRESS AND CIRCULAR, we commented upon the somewhat unusual fact of the employment of antitoxic serum as a remedy for cerebro-spinal meningitis. The whole question of toxins and anti-toxins is still involved in an obscurity which modern bacteriological research has not hitherto been able to penetrate. Nevertheless, facts are facts, and if it be clinically proved that diphtheria antitoxin is useful in counteracting the poisons elaborated by other organisms, it must, in due time, find a recognised place in our therapeutic armament. A case has just been reported by Dr. Robert T. Legge (*Journ. Amer. Med. Assoc.*, April 22nd, 1905) in which exophthalmic goitre was distinctly benefited by antitoxic serum. The fact was discovered, so to speak, accidentally, for the patient was the aunt of a little girl suffering from diphtheria in whom tracheotomy was performed. In nursing the child the lady also contracted the disease, being affected at the same time with Grave's disease. Diphtheria antitoxin was injected subcutaneously in the ordinary way, and four months later it was observed that her large tumour in the neck had almost disappeared, and that the ocular symptoms were distinctly better. Two other cases, one of simple, the other of exophthalmic

goitre, were afterwards treated by Dr. Legge with injections of antitoxic serum, quite from an experimental point of view with results that more than justified his anticipations. One of the most noteworthy effects of the remedy was the reduction in size of the thyroid swellings, the parenchyma of the tumour seeming to shrink up. Against the suggestion that the improvement in the first case might have been due to the neutralisation of some toxin elaborated in the thyroid gland by the diphtheria poison itself, apart from the antitoxin injected, is the fact that the two other patients did not suffer from diphtheria at all. The value of such observations as these cannot be minimised, even though the treatment advocated appear somewhat empirical.

Nursing in Paris.

At the time of the visit of French medical men to London last year there was nothing which more excited the admiration of our visitors than the nursing arrangements of the London hospitals. The same point has been singled out for praise by French surgeons visiting the great medical centres of the New World. There is little doubt, indeed, that nursing arrangements in Paris and the status of the hospital nurse in that city are much below what we are accustomed to in these countries and in the States. After the expulsion of the religious from the Paris hospitals some twenty years ago, the nursing staff was filled by women of very low class, and although much improvement has been made since that time, much remains still to be done. M. Mesurier, the present Directeur-Général de l'Assistance Publique de Paris, during the two years he has been in office, has devoted himself specially to the improvement of nursing, and has done much to enforce a better discipline than formerly obtained, and to hold out inducements to well-educated women to adopt nursing as a profession. M. Mesurier not long ago sent M. Montreuil, of the Salpetriere, to study the nursing question and hospital administration generally in London, and he has endeavoured as far as circumstances permit, to model the Paris system according to M. Montreuil's scheme, copied from London. Quite recently, by M. Mesurier's suggestion, Madame Zola, the widow of the great novelist, has presented her chateau of Médan, which she can no longer afford to occupy, for the use of old, infirm, and sick nurses. The example of consideration for nurses thus publicly shown, cannot but help to develop that dignity and pride in their profession which is necessary if it is to take its proper place in the estimation of the public.

"A Queer Story."

Our contemporary *Truth* contains in a recent number a medical "queer story" of some interest. It relates how a patient suffering from melancholia with suicidal tendencies succeeded in poisoning himself by distilled water. The doctor, in whose house the patient resided, having determined to test how far subjective expectation could influence vital action, left exposed a medical dictionary

lying open at the article on opium poisoning, and near by a bottle of coloured distilled water, labelled "Laudanum—Poison." He watched his patient discover the book, read the article, and finally steal the bottle. Nothing further was seen of the patient until his body was found, apparently dead of opium poisoning, the bottle lying empty beside it. That imaginary poisoning may produce death has been made clear by one or two recorded cases. In particular, a case occurring in Hull a year or two ago, will be remembered. A girl asked for a bottle of laudanum at a druggist's, but the druggist, suspecting her intentions, supplied her with port wine. This she drank, dying in a short time with all the symptoms of opium poisoning.

The Board of National Education in Ireland and Tuberculosis.

We are glad to note the interest taken by the Board of National Education in Ireland in the subject of hygiene, and the endeavours they are making to impress on teachers and managers their responsibility in regard to the prevention of disease. Last autumn a representative and influential deputation waited on the Resident Commissioner to impress on him the necessity of taking every step to instruct teachers and pupils in the methods of preventing the spread of tuberculosis, and we are glad to see that the interview has borne fruit in the issue of a special circular to the managers and teachers of primary schools throughout the country. In this circular, teachers are directed to "take frequent occasions of explaining to their pupils the necessity for the observance of hygienic rules both in regard to tuberculosis and to infectious diseases generally." It is pointed out that consumption is a disease due to living germs, and that children should be taught how to avoid infection. Teachers are reminded that there are several treatises on hygiene already sanctioned for use in national schools, suitable for purposes of instruction. The circular is important, not so much on account of what it actually contains, as because it shows a willingness on the part of the Board to accept a responsibility in the matter of instruction regarding the prevention of disease.

Compulsory Treatment.

WHATEVER may have been done in England in the way of faddist legislation surely pales before the proposal introduced into the New York Senate by a certain Mr. Carpenter. This individual brought in a Bill for the treatment of inebriates and persons addicted to the use of drugs, which rises to a height of impertinence that is perfectly incomprehensible in this country. Section I. of this remarkable Act gives a magistrate power when he finds a person guilty of drunkenness, or of crime committed under the influence of drink, to direct that such person shall be made to undergo the "Oppenheimer" treatment. Section II. is even more astounding, for if a magistrate certifies to the warden of a prison that such a person committed his offence under the influence of drink,

the Oppenheimer Institute may compel him to undergo their treatment. Finally, any person in a penal or charitable institution may at his own request be treated by the Oppenheimer Institute. For all such treatments, whether at the magistrates' order or the patient's request, the town or city to which the patient belongs shall pay the Oppenheimer Corporation the sum of twenty-five dollars. One rubs one's eyes to see if one is awake after reading this colossal piece of impertinence. It can hardly stand a chance of passing into law, and is probably only an elaborate advertising dodge, but it makes one wonder what sort of a member of Senate would make himself party to such a transaction.

Dirt in Milk.

A CASE that was recently tried before one of the Metropolitan magistrates illustrates—if illustration were needed—the vital necessity of some effective control over the milk supply. The defendants were milk contractors, and they were summoned for supplying milk that was deficient in fat. The defence alleged that the milk was bought from farmers under warranty as to its purity, and that it was supplied to the plaintiffs in the same state as that in which it was received. In the course of the trial it came out that the milk after arriving in London, was taken to the contractors' depot and strained to remove possible dirt. The magistrate held that this admission invalidated the defendant's contention that the milk was delivered in the condition in which it arrived, and accordingly he imposed a fine. It appeared that large sums were paid to analysts every year by the contractors, but if it was found necessary to strain the milk to rid it of gross dirt, the analysts' fees would, we think, have been far better spent in paying an inspector to see that reasonable cleanliness was observed by the milkers.

Lunacy Legislation.

MOST sessions of Parliament see some one or more bills dealing with questions of lunacy administration, and the present one contains a measure which it may be hoped will not suffer extinction in the annual "massacre of the innocents." Introduced by the law officers of the Crown, it embodies not only the substance of a useful bill of last year for the provision of private care for incipient cases, but contains several other enactments. These latter are no doubt the outcome of the debates that have taken place in the past in the amount of work that devolves upon the Commissioners in Lunacy, whose number has remained stationary while their duties have increased enormously. The first provision in the measure is, to a certain extent, retrogressive, as it seeks to enable one commissioner, appointed by his brethren, to perform duties which it was previously necessary for two to carry out in conjunction. Although at the present day this power is not likely to be

abused, it *pro tanto* reduces a public safeguard against personal *animus* or carelessness. The next provision is that the Lord Chancellor shall have authority to increase the numbers of the Commission by adding one legal and one medical member. This will do something to reduce the present inadequacy of the Commission, an inadequacy which is strikingly apparent when the strength of the Scotch Commission in comparison with the population is brought into consideration. There are other clauses of an administrative nature, besides two which make private care on a single certificate legal. The Bill as a whole will have the approval of the medical profession, though it would have desired to see a larger number of Commissioners added.

Lumbar Puncture.

THE occurrence of sporadic cases of cerebrospinal meningitis in different parts of the British Isles will put all medical men on the watch for instances of the disease in their own practice. Naturally, too, since the malady is but little known, they will be anxious definitely to establish their diagnosis at the earliest possible moment. The most certain and efficient method as yet known is by lumbar puncture, and in this connection it will be interesting to compare the experience of our German colleagues, who are more accustomed to the procedure than we ourselves. The operation of lumbar puncture is so simple a one that it is classed with "physicians' operations," such as tapping chests and giving hypodermic injections, but that it is not without danger is shown by a statement of Gerhardt, who last year collected from medical literature accounts of twenty-six deaths following lumbar puncture. To these, he sagely remarked, there must be added all the unrecorded ones. This year, before the Berlin Society of Pyschiatry and Neurology, a discussion was raised on the legitimacy of the proceeding when performed for diagnostic purposes. Several physicians agreed that lumbar puncture had been greatly overdone, and that short of actual death, a series of symptoms may follow that are imperfectly understood. Dr. Zichen said that he thought lumbar puncture was practically a safe procedure if carefully done, but that it was always well to warn the friends that there was an element of risk before undertaking the puncture. In the face of these opinions it may well be questioned if it is wise for punctures to be performed light-heartedly; if a calamity occurs in the course of an operation which is being carried out merely for diagnosis, the practitioner's reputation is likely to suffer considerable damage.

Chinese Manners.

FROM an interesting paper on "Ærophagia and Flatulence," in the *New York Medical Record* (April 29th), we learn some curious facts about the gaseous changes in the intestine. Dr. Spivak, the author, speaking of voluntary eructations of gas from the stomach, quotes the following quaint

custom as illustrating the amount of control that may be gained over the movements that produce the expulsion of gases. In China, it is the habit of a host to deprecate any worth in the hospitality he offers his guests, a form of self-negation that is considered the highest politeness. After a banquet, speeches are not made, but the host rises to say that he fears his guests have fared but poorly, that it is a shame to have asked them to so meagre a repast, and that he feels sure their hunger is not appeased nor their thirst abated. Loud protests rise from the guests, who vie with each other in lauding the quality of the viands and the excellence of the liquor. When the complimentary epithets of their vocabulary are exhausted, they rise and approach their host in turn, each as he reaches him placing his hand on his belly and bringing up wind in his face to testify to the richness of his hospitality. This is after-dinner gas with a vengeance.

Vibration as a Tonic.

THE law of periodicity or rhythmicality has a wide application in the physical world. Many of the functions of the human body also possess a definite periodic or cyclic character, which property must necessarily influence the treatment of disease. Attacks of migraine, for instance, may often be warded off altogether by a stricter attention to the laws of health during the intervals of comparative immunity from the affection. With regard to the actual application of physical vibration of high frequency to the body, there are those who ardently believe in its therapeutic efficacy. Revolving spheres, of varying sizes, driven by electric motors, are now brought to bear with fearful velocity upon the bare spine, under the supposition that the exaggerated tremulant effect thereby produced will act favourably upon exhausted spinal or cerebral nerve-centres. The unaccustomed stimulus transmitted by the sensory nerves is alleged to increase anabolic change within the nerve-cells and to induce restful sensations generally. It is difficult to comprehend exactly how the so-called "vibratory massage" acts, but we fear that it is often undertaken by unskilled hands, and often in totally unsuitable cases. The fact that instruments of a mysterious yet attractive appearance are now on sale in chemists' shops in the metropolis is greatly to be deprecated, especially when the vibratory effects which they are said to produce are stated to act little short of a panacea for all sorts of diseases. The door is thus opened to another insidious form of quackery. There are some conditions in which vibration of any sort communicated to the sensorium is positively harmful, yet we find that riding in a motor-car, trembling and shaking all over, is recommended as a powerful "nervetonic of locomotion" for weary and jaded humanity. One must proceed cautiously before the seal of "the faculty" is affixed to this form of physical therapeutics.

Tea and Neurasthenia.

CERTAIN statements as to the harmful effects of tea-drinking that have recently gone the round of the public Press have created no small stir among individuals of controversial tendencies. It is the old story. Conclusions are hastily drawn from isolated cases of excess, and irreparable injury to delicate nervous tissues, and so on. One is almost tired of reading these pseudo-scientific arguments, of the publication of which there is no end. It has been freely alleged that the modern malady of neurasthenia—a pet name with medically-minded laymen—was the offspring of tea-drinking, pure and simple. The complex character of the changes brought about by functional disturbances of the cerebro-spinal nervous system are too well recognised to allow of any one cause being laid down as the predisposing or exciting one. The neurasthenic may consume tea to excess as he may any other beverage, for lack of control is always the chief underlying factor of his complaint. Whatever type the disease may assume, in either sex, instability of nerve-force and will-power are characteristic features, so that any slight stimulus may evoke reaction of nerve-centres in an unaccustomed direction or to too great an extent. But no one with any knowledge of the relative effects of tea and alcohol upon the whole system, whether habitually taken in small quantities or now and then indulged in to considerable excess, would seriously aver that the tea possessed anything like the deleterious influence exerted by strong drink. Every practitioner is aware of the ill effects of tea when given to infants, to the dyspeptic and to the neurotic student, more particularly when it is badly made. Leaflets conveying simple instructions how to make tea wisely and well might be distributed to poor hospital out-patients with advantage, for even in these days of popular science and health lectures there are thousands who still remain ignorant as to the proper management of the teapot.

Policemen as Scientists.

IT is well for everyone that members of the police force should everywhere be well educated and, in some branches of their work, highly trained. There is a danger, however, that they may mistake the "little knowledge" of the amateur for the full and finished powers of the professional, as, for instance, in so difficult and highly technical a branch of scientific work as that involved in identification by finger prints. Many worthy citizens think that an ex-constable is competent by mere virtue of his former occupation to become a sanitary inspector or a finger-print expert, or to hold other posts more or less indirectly concerned with scientific administration. A most amusing instance of the kind is the attempt recently made at Harrogate to appoint an ex-police inspector as general superintendent and manager of the wells and baths of that famous health resort. To put the matter in another way, it is proposed to place

a highly complicated organisation, demanding an acquaintance with a number of advanced modern therapeutical methods and appliances, to say nothing of the various medicinal springs, in the hands of an unscientifically trained man of fifty, who is furthermore said to have retired from his late post on account of ill-health. Well may the townsfolk, headed by the local medical men, rise up in arms against such folly. Of all places in the world, Harrogate wants wise heads to guide, govern, and direct and develop her magnificent natural resources.

A Surgeon on the Chair.

THE effect of any sedentary occupation upon health must always be taken into consideration when investigating the cause of a given malady. Few callings are totally exempt from their own special diseases. The sitting posture, however, is so universally adopted by all sorts and conditions of men that it is somewhat strange that no one has specially set himself to hurl anathema at the chair or stool upon which men and women perform their allotted daily tasks. Mr. Noble Smith, in a recent lecture, has boldly denounced the chair, which he is said to regard as "the cause of nearly all our evils in regard to the spine." The crouching or stooping attitude assumed by almost every child when studying, unless carefully watched, is certainly one to be most strongly condemned. The best arrangement is that which brings up the desk and work nearer to the pupil's eyes, at the same time providing a suitable support for the back and shoulders. The "new machine that became a chair" is as restless now, in many cases, as was the primitive type described by Cowper whose "back erect distressed the weary loins, that felt no ease." The habit which "taught the raised shoulders to invade the ears" was fully recognised by the poet as undesirable, and he would, doubtless, have been quite in sympathy with the attempts of modern orthopædic surgeons to render the chair, as commonly used, less of an evil than it already is. Mr. Noble Smith believes that the best way to counteract the bad effects of the studying attitude in a child is to teach it to study in the prone position, resting upon its elbows, with the book open before it. The couch upon which it lies when in this posture must be suitably sloped. Apart from the effects of mal-position, the chair or stool has been credited with producing, or, at least, aggravating, other affections characterised by pelvic or perineal congestion, but in this connection the question of the nature of the lining or surface of the seat must be considered.

Bubonic Plague in Scotland.

THE news that cases of bubonic plague have been imported into Leith would in past years have created more or less of a national panic. Nowadays the invasion excites little interest outside the locality immediately invaded. Bubonic plague, like cholera, is one of the diseases that

experience has shown has little chance of obtaining a foothold in the United Kingdom, thanks chiefly to the careful control of our ports and to the excellence of the national drinking water supply. The prevalence of an irreducible minimum of enteric fever cases, however, shows that perfection has by no means been yet universally attained within our shores. The typhoid outbreak at Lincoln, for instance, reveals a gross and long-continued contamination of the town's water supply that is a scandal and a disgrace to the town, to the Local Government Board, and to our national sanitary system. Were a case of bubonic plague to occur in the neighbourhood of Lincoln under present conditions the citizens would infallibly die of the disease by thousands. At Leith one man has died, while his wife and child are still suffering, and some thirty exposed persons have been isolated. Rats are being killed wholesale in the port, and with the vigorous precautions that have been enforced there is little need for apprehension. The man attacked was a tramcar conductor, and his wife worked in a rag factory; but the origin of the infection has not yet been traced.

The English Visit to Paris.

IF the *entente cordiale* depended on the mutual friendliness of members of the medical profession on both sides of the Channel, the way to the millennium would be considerably smoothed. The reception of our countrymen in Paris may be described as magnificent. Full details will be found elsewhere in our columns in the shape of a special descriptive article from our special correspondent in Paris. One great feature in the reception was the absolute attention to detail throughout, so that the Englishman was made to feel he was a privileged and welcome guest from the moment he put his foot on French soil until the time he left it. Hospitality was ample and unbounded, and everything was conducted on a lavish scale. There is much to be learnt from our French *conféres*, perhaps more especially in the way in which they act loyally to one another in the matter of patients and fees. It will repay any Englishman on future occasions to take the opportunity of making a closer acquaintance with professional life, as carried out by our lively and talented French neighbours.

PERSONAL.

THE King has appointed Mr. Charles Edwin Truman, M.R.C.S., to be Dentist to his Majesty's Household, in room of Mr. Edwin Thomas Truman, deceased.

PRINCESS CHRISTIAN will present the awards of the National Health Society at Grosvenor House on Tuesday, the 30th inst., at 3.30, when the Earl of Derby will preside.

It is intimated that Dr. W. Ford Robertson has been appointed Morison Lecturer for the ensuing session at Edinburgh University.

W. J. LANCASTER, Esq., J.P. (ex-Mayor of Wandsworth), will preside at the annual dinner of the Royal

Hospital for Incurables, at the Savoy Hotel, London, on Friday, June 30th, at 6.30 for 7 p.m.

It is announced that Baron von Schröder will preside at the sixtieth anniversary festival of the German Hospital, which will take place at the Hotel Cecil on June 6th.

THE London Congress of the Royal Institute of Public Health will be held from Wednesday, July 19th, to Tuesday, July 25th. Those wishing to contribute papers should communicate at once with Dr. George Carpenter, Welbeck Street, London, W.

MR. HENRY MORRIS delivered the Annual Oration before the Medical Society of London on Monday evening last, on the financial relations existing between the London hospitals and the associated medical schools, and the bearing of these relations on medical education in London. The guests were previously received by the President.

A PAPER on "Plague in India" will be read by Dr. Charles Creighton, author of the "History of Epidemics in Britain," before the Indian section of the Society of Arts, to-morrow (Thursday) afternoon. The chair will be taken at 4.30 by Sir Dennis Fitzpatrick, Member of the Council of India.

AT the last meeting of the Council of the Medico-Psychological Association, Dr. Outterson Wood was unanimously elected to be President-elect, in the room of the late Sir John Sibbald.

THE sixth annual meeting of the American Therapeutic Society was recently held at Philadelphia, under the presidency of Professor O. T. Osborne, with the assistance of Professor John V. Shoemaker as Chairman of the Committee of Arrangements.

SIR CHARLES BALL, F.R.C.S., has been appointed a Commissioner of National Education for Ireland.

THE annual meeting of the Colonial Nursing Association will, by permission of the Duke and Duchess of Marlborough, be held at Sunderland House on Wednesday, June 7th, at 3.30 p.m. Princess Henry of Battenberg has signified her intention to be present, and the Earl of Westmeath will preside.

MR. HERBERT J. PATERSON, F.R.C.S., to whom the Jacksonian Prize was presented by the President of the Royal College of Surgeons, England, on Thursday last, is well known in surgical literature, his latest achievement being the editing and rewriting much of the late Mr. Walsham's well-known work on "Surgical Pathology," the third edition of which has recently been issued from the press.

MR. JOHN TWEEDY, F.R.C.S., President of the Royal College of Surgeons of England, has been elected as a representative of the College on the Court of Sheffield University.

SIR WM. BROADBENT, Bart., Physician to his Majesty the King was on Saturday, last decorated with the cravate of Commander of the Legion of Honour in connection with the visit of Medical men from this country to Paris.

THE design sent in by Mr. W. A. Pite, of the firm of Messrs. Pite and Balfour, for the new King's College Hospital has been awarded first place. The committee has also appointed Mr. Pite to act as the architect of the new hospital.

THE annual general meeting of the Medical Defence Union (Limited), will be held at the Medical Society's Rooms, 11, Chandos Street, W., on Thursday, May 25th, at 5 p.m., to receive the annual report for 1904, &c.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

SCOTLAND.

BUBONIC PLAGUE AT LEITH.—Bubonic plague, believed to have been imported by rats from a foreign vessel arriving at the docks, has been discovered in a tenement in Leith. One man, a labourer, has died, and his wife and two children are suffering from the disease. The diagnosis has been confirmed by Dr. Chalmers, medical officer of health, Glasgow, and Dr. Buchanan, the municipal bacteriologist, both of whom had considerable experience of the disease in an outbreak which took place in Glasgow several years ago, so that there can be no doubt that the Leith authorities are just now confronted with this most formidable disease. Energetic measures are being taken, an extra staff having been engaged by the public health department, including two medical men, whose duty it will be to keep a special watch on families in the neighbourhood of the tenement in which the disease appeared. It is thought that some affected rats were concealed in a quantity of rags imported from the East; the wife of the man who has died, and who is herself now suffering from plague, was a worker in a rag-store, and states that she saw rats running about while she was occupied in sorting therags. The attention of the authorities has been specially directed to this rag-store, and the services of several rat-catchers have been secured. The three persons affected have been isolated in Pilton Fever Hospital, and at present only one of them is regarded as being seriously ill. The trade at Leith harbour and docks will inevitably be affected, especially as the Baltic trade is now opening for the season. The fact that the disease has broken out in one of the poorest parts of the town increases the likelihood that some fresh cases may arise before the disease is finally stamped out.

THE VALUE OF BACTERIOLOGICAL EXAMINATION IN DOUBTFUL CASES.—At the monthly meeting of the Clydebank and Renfrew Joint Hospital Board, a letter was read from Dr. Gilmour, of Dalmeir, complaining that a patient reported by him as suffering from typhoid fever had been admitted to the hospital and sent home a few days later. Since that a bacteriological examination of the blood showed the Widal test reaction, indicating, so far, the diagnosis of typhoid as the correct one. Dr. Gilmour stated that his professional reputation was at stake by the action of the hospital doctor. In reply, Dr. Buchart said the Widal test was regarded as a relative, but not as an absolute one, and that he relied on the clinical symptoms. This case shows very plainly the responsible, and often the delicate, position of the medical superintendents of hospitals for infectious cases of disease, and the need for the exercise of the greatest possible care in the discharge of their, at times, embarrassing duties. As an outcome of this case an arrangement is now being made whereby a bacteriological examination will be made in all cases involved in any doubt.

TESTIMONIAL TO DR. THOMAS J. F. MESSER, HELENSBURGH.—Dr. Messer, who has practised in Helensburgh for the long period of thirty-three years has just been made the recipient of an illuminated address and two purses, containing respectively £220 and £20, the smaller being the gift of the Lodge of Oddfellows. Mrs. and Miss Messer were also presented with gold bracelets. The occasion was the retirement of the doctor from the active practice of his profession. He was for a long period of years captain of the local artillery corps, and for his services received the long service medal.

BELFAST.

ROYAL MEDICAL BENEVOLENT FUND SOCIETY.—The annual meeting of the Belfast and County Antrim branch of this Society was held in the Medical Institute, Belfast, on Friday, May 12th. The president of the branch, Dr. Joseph Nelson, in the chair. The hon. secretary and treasurer, Dr. R. J. Purdon, read the report and statement of accounts for the past year, which

showed that the total sum received by him was £154, including a donation from the funds of the Ulster branch of the British Medical Association of £5 5s., a student's contribution of £6, and £8 16s., the proceeds for the now customary collection made at the annual dinner of the Ulster Medical Society, in the ancient bleeding bowl presented to the Society by Sir Wm. Whitla. After all the local expenses were paid, £144 was remitted to the head Society, a slight falling off from last year. It was greatly to be regretted that of more than 200 members of the profession in Belfast, seventy refused to contribute. To country practitioners 185 copies of the appeal had been sent, and only 42 answers received. The local grants received amounted to £127. These reports were moved by the president, and seconded by Professor Lindsay, and passed. Dr. Cecil Shaw moved, and Dr. Fielden seconded, the appointment of the committee. Professor Symington moved, and Dr. Purdon seconded, the re-appointment of Dr. Nelson as President, and Sir Wm. Whitla moved, and Dr. Marion Andrews seconded, a vote of thanks to him for presiding.

MEDICAL GOLF MATCH.—The first part of the match for the Lindsay Challenge Cup for medical golfers was played off at Ormeau, Belfast, on Thursday, May 11th, and resulted in the following eight qualifying for the second part of the competition, which is played by holes:—Dr. McIlwaine, 87—20=67; Dr. Baillie, 78—9=69; Dr. Carnwath, 94—24=70; Dr. McCaw, 96—24=72; Dr. Robb, 88—16=72; Dr. White, 83—10=73; Dr. R. J. Johnstone, 92—18=74; Dr. T. Houston, 95—20=75.

A BELFAST OPINION ON THE "IRISH MEDICAL DIRECTORY."—We have received the following note from a correspondent:—At the special meeting of the Ulster Medical Society, held on the 11th inst., to consider the subject of "The Direct Representation for Ireland on the General Medical Council," the attitude of both candidates with regard to the publication by the "Irish Medical Directory," was brought forward, as both are members of the Irish Medical Association. It was hoped that no one would be selected who was not above suspicion and prepared to defend the time-honoured ethics of the profession. There is a very strong feeling that the profession has suffered a gross degradation, and that simply shirking the responsibility is not sufficient, but that the Council of the Irish Medical Association should enforce an apology to those who have been slighted, withdraw the publication, and guarantee no repetition of the insult. Dr. Allworthy, of Belfast, has placed the matter before the Council of the London and Counties Medical Protection Society for consideration.

[Our correspondent has anticipated the expression of our own opinion on this important question. We entirely concur with him in thinking that it is both necessary and proper that candidates for the post of direct representative should state clearly their opinion on a matter so closely connected with medical ethics.—ED.]

Obituary.

JAMES SHIMELD, L.R.C.P. & S.ED., L.S.A. DUB.

By the death of Dr. J. Shimeld, which occurred recently at his residence, Ilford Broadway, the district loses one of its oldest residents, who was at one time its most prominent medical man, enjoying a very large and lucrative practice. Dr. Shimeld had been ill for a long time past, and his demise at the comparatively early age of fifty-seven was not unexpected. He graduated L.R.C.P. and S. Edin. in 1876. The deceased gentleman was originally in practice in Ilford with Dr. Sullivan, whose daughter he married. He leaves one son.

THOMAS CREED, M.D. ST. AND., M.R.C.S. ENG., L.S.A.

An old and respected practitioner, Dr. Thomas

Creed, recently died at Boscombe, at the advanced age of seventy-nine, after a painful illness borne with great fortitude. From 1851 he practised for forty-five years at Greenwich, and did good service amongst the poor. For more than forty years of this time he was honorary medical officer of the Royal Kent Dispensary; upon the foundation of the Miller Hospital he was appointed honorary physician. This post he held till 1891. In 1876 Dr. Creed was president of the West Kent Medico-Chirurgical Society, and took a keen interest in its meetings.

RICHARD GILBERTSON, M.R.C.S., L.S.A.

An interesting figure in the town of Aberystwyth has been removed by the recent death of Dr. Gilbertson. He had reached the ripe age of eighty-seven years, and had lived in the town practically the whole of his life. Born at Cefngywn, near Aberystwyth, he went to London and studied at St. Bartholomew's, where he subsequently took his qualifying degree, becoming M.R.C.S. in 1840. Failing health compelled Dr. Gilbertson to relinquish his practice about fifteen years ago. He had acted as one of the honorary surgeons of the Infirmary, and had also been one of the official trustees and a member of the management committee. Although not so well known to a younger generation, he was regarded with the greatest esteem, and his death is keenly regretted amongst a large circle and his family of seven children.

Laboratory Notes.

NURSING OXO.

THIS is a new preparation, prepared by the Liebig's Extract of Meat Company, who are so favourably known as the manufacturers of Lemco and Oxo. Nursing Oxo is, as the analysis shows, more concentrated than Oxo, and is a compound of meat peptone, meat essence and fibrine. As it contains such a very high percentage of nitrogenous principles (to which the useful properties of such preparations are due) it can be unhesitatingly recommended for use in the sick-room, in those cases where it is desirable to employ one of these preparations. Our analysis shows the composition of this product to be as follows:—

Water, 19.55 per cent.

Mineral matter, 14.37 per cent.

Nitrogenous matter, 61.08 per cent.

The mineral matter is not excessive, and the flavour is excellent. In the case of invalids whose appetite is capricious, the pleasant flavour of this preparation will cause it to be taken readily and its highly stimulating properties should lead to its wide adoption.

PIONEER MILK SUGAR.

THIS milk sugar has recently been introduced for use in those cases where breast milk for various reasons is not available, and where the expense of humanised milk renders its use prohibitive. This brand of milk sugar (The "Pioneer" Milk Sugar Company, 24, Minories, London) is a distinct advance on most commercial milk sugars, and can be safely recommended to those in charge of infants, for the production of an infant's food, which, when prepared from cow's milk of good quality and cream, in accordance with the directions given, will be found to approximate to the composition of normal breast milk. Our analysis shows the following figures:—

Moisture, 0.1 per cent.

Ash, 0.03 per cent.

There is no acidity, and no curdling took place on boiling with milk.

A MEMORIAL to the late Dr. Muir, of Briercliffe, Burnley, was unveiled last week in the shape of a handsome red and grey granite drinking-fountain, costing £120, which was subscribed to by practically every householder in the township.

A SUM of £5,000 has been provided in the Egyptian estimates for the current year, with the object of taking some preliminary steps towards the establishment of a statistical service.

Literature.

DAWSON'S SHIP SURGEON'S POCKET-BOOK. (a)

THE small work before us fills a niche in medical literature of considerable importance. Generally speaking, those who engage themselves as ship surgeons are novices and have little or no idea of what may be expected of them during the voyage. The writer has had a very large experience as medical officer on various trips to all parts of the world, and as he tells us in his preface, he has "not lost a patient." This pocket guide is arranged alphabetically, and gives in condensed form information on medical and geographical matters which the young ship surgeon is sure to need at some time or other. The notes on the important places touched at are wonderfully concise, and yet distinctly practical; while the more distinctly surgical topics are skilfully handled. Under the heading, "Voyages," the author gives the time occupied from port to port, and the order of the places visited, and these specifications will be of great service to an officer making any of these voyages for the first time. Brief vocabularies in Japanese and Hindustani are included, while a number of interesting points, such as the various forms of certificate granted by the Admiralty, are given in an appendix. Several blank pages are added for the record of interesting cases, and other notes that may be necessary. This is just the sort of book a young ship surgeon requires when entering upon his new duties, as it gives the amount and kind of information most likely to be required during a voyage to foreign parts. It should be in the hands of every medical officer afloat.

DISEASES OF THE HEART. (b)

THE object of this book, the second edition of which we welcome, is to deal "with the clinical side of the subject of heart disease in a form suitable to the requirements of the student and newly-qualified practitioners of medicine," and we must heartily congratulate the author on the manner in which he has attained this object. The book opens with two introductory chapters on the anatomy and physiology of the heart. The treatment of these subjects, from limitations of space, must necessarily be brief, but in some respects—for instance, the relations of the heart—usefulness seems to have been sacrificed to brevity. We notice, also, a curious error both in the diagram and description of the arrangement of the semi-lunar valves of the aorta and pulmonary artery. The chapter on the "Methods of Diagnosis" appears to us to be particularly good, and the plan of discussing the value of the various symptoms and signs generally is one which is of special use in dealing with a complicated subject like heart disease. In this connection we would wish to draw special attention to the section dealing with the cardiac murmurs, which appears to us to be particularly well done. We are quite in agreement with Dr. Colbeck in his adoption of Foxwell's explanation of the method of production of the pulmonary systolic murmur of cardiac debility.

We doubt very much if there is any very great value to be derived from the use of the sphygmograph or cardiograph in clinical medicine. Such instruments in the hands of any but skilled operators are more likely to be misleading than useful, and consequently the introduction of detailed descriptions of their use and results are, we believe, of little value in a work like the one under consideration. By far the most difficult question in connection with disease of the heart is that of prognosis; it is the one, too, on which the junior practitioner requires the most assistance. This being so, we regret that Dr. Colbeck has not devoted more space to the consideration of this part of his subject. Accurate and complete descriptions of the

various forms of cardiac disease can be found in most text-books of medicine, but it is only in special works that one would expect to find any full and complete discussion of the problems of prognosis. There is one other striking omission to which we feel we should call attention, and that is the absence of any reference to the influence of pregnancy on the course of chronic cardiac disease. In spite of these omissions the book, we feel sure, will fulfil a useful purpose, and we congratulate the author on having produced such a well-written and trustworthy manual.

LANDOIS ON PHYSIOLOGY. (a)

WE most gladly welcome the production of a new English edition of this most reliable and valuable work. It is now a considerable time since the publication of the fourth edition of Professor Stirling's translation, and that edition has been for some years out of print. In the meantime, three more large editions of the original work have been published in Germany, and consequently the present edition represents the tenth German edition. In the case of the edition before us the translation has been performed by Professors Brubaker and Esher of Philadelphia. We were under the impression that Messrs. Griffin intended that this edition should take the place of Professor Stirling's translation, and are therefore much surprised to find that the same publishers announce as "in preparation" a fifth English edition, translated by Professor Stirling from the seventh German edition. It is true that Professor Stirling's work contains annotations and additions, but, nevertheless, if it is to compete successfully with the American translation, it should be prepared from the last German edition.

A work which has run through so many editions calls for little criticism. It has been extensively revised, and the results of the most recent investigations have been included. Further, the number of illustrations has been increased. The general plan of the book is to teach physiology in its relation to practical medicine, and it is doubtless this that has made it so popular in the past. In its present form, we believe that it will further enlarge the circle of its readers.

HIRST ON DISEASES OF WOMEN. (b)

THIS text-book is fairly complete and up to date, and for the most part compiled in accordance with the most modern views. The arrangement of the book generally is good, though in one or two places the author's order of things is difficult to follow from a student's point of view; for instance, retro-deviations of the uterus are discussed before metritis, endometritis, &c. Surely this is largely a transposition of cause and effect? The methods of examination are clearly detailed and well illustrated. The author advocates the use of rubber gloves in any suspicious case. Would it not be better to use them in all cases for one's own sake and for that of the patient? The description of the Alexander-Adams operation is clearly written, and is of interest particularly at the present time, when this operation is being revived in these countries after many years' disuse and so many conflicting opinions as to its permanent results exist. The round ligaments are not always so easy to find and pick up as the author's words would lead one to suppose.

Atmocausis and zestocausis are considered by the author to be unsafe methods of treatment, and are dismissed in a few lines; but in view of the fact that excellent results have been obtained by their use it

(a) "Text-book of Human Physiology, including Histology and Microscopical Anatomy, with especial reference to the Practice of Medicine." By Dr. L. Landois, Professor of Physiology and Director of the Physiological Laboratory in the University of Greifswald. Tenth revised and enlarged edition, edited by Albert P. Brubaker, M.D., Professor of Physiology in the Jefferson Medical College and translated by Augustus A. Esher, Professor of Clinical Medicine in the Philadelphia Polyclinic. Pp. 1027, with 394 illustrations. London: Charles Griffin and Co., Ltd. 1904.

(b) "A Text-book of Diseases of Women." By Barton Cooke Hirst, M.D. Philadelphia: W. B. Saunders and Co., 1904.

(a) "Ship Surgeon's Pocket Book and Medical Officer's Log." By W. E. Dawson, formerly Admiralty Surgeon and Agent, &c., London: Bailliere, Tindall and Cox, 2s. 6d. net. 1905.

(b) "Diseases of the Heart: a Clinical Text-book for the Use of Students and Practitioners of Medicine." By Ed. H. Colbeck, M.D. Second Edition, revised and enlarged. London: Henry Kimpton, 1904. Price 7s. 6d. net.

would be impossible to lay them aside as a *dermivressort* before hysterectomy.

The illustrations are numerous and for the most part good, many of the micro-photographs being excellent; but there is in this work, as in many of the American text-books, the tendency to over-illustrate. Now this may be described as a good fault, but should not lead the author to insert such illustrations as are found on pages 33-34.

THE MODERN TREATMENT OF CONSUMPTION. (a)

The fact that Dr. Arthur Latham's excellent little manual on the modern management of pulmonary tuberculosis has speedily passed into a second edition, furnishes abundant evidence that it has made for itself a prominent place among the many works purposing to serve as guides to the hygienic treatment of consumption.

In the present edition there is but little alteration in the scope and character of the work. The pathological features of the disease are very briefly described, and considerable space is devoted to a study of diagnosis. The main portion of the work deals with the principles and details of so-called open-air methods. These are well expressed, and, generally speaking, the conclusions are judiciously and practically presented. The work will be of considerable service to general practitioners in assisting in the selection of cases for sanatorium treatment, and in their subsequent supervision.

Dr. Latham writes rather from the standpoint of the academic and scientific physician rather than from the view point of one who is in constant contact with sanatorium life in all its perplexing details. Although always clear and fair in his descriptions of the various factors which go to form what has been well spoken of as the hygienic treatment of consumption, there is not lacking at times a ring of philosophic doubt and therapeutic agnosticism.

We could have wished that the real scientific principles which underlie the modern management of consumptives had been more completely discussed. The value of the book would have been greatly enhanced if references had been given to the works of the many authorities quoted.

We are inclined to take exception to some of Dr. Latham's suggestions. The advice conveyed in the following seems lacking in altruistic tendencies:—"By means of marriage tuberculous individuals are enabled to lead a more regular life, and to avoid various forms of temptation to a greater extent than in any other way."

We also do not agree that "if reasonable precautions are adopted, there is no reason why the children of tuberculous parents should develop the disease more frequently than the offspring of those who are not tuberculous."

Dr. Latham's advice respecting the use of alcohol is not in accordance with the best experience, and such directions as that "when the temperature is elevated or the digestion disordered, both brandy and champagne are exceedingly useful" is almost ludicrous in its unscientific vagueness. But in spite of some sins of commission and certain regrettable omissions, the work is undoubtedly one of considerable practical value, rich in facts, full of suggestions, and eminently serviceable. Every practitioner desirous of obtaining a comprehensive survey of the modern treatment of consumption would do well to study carefully this well-arranged and attractively-written monograph.

BRUNDAGE ON TOXICOLOGY. (b)

This is an excellent little book of about 400 pages.

(a) "The Diagnosis and Modern Treatment of Pulmonary Consumption, with Special Reference to the Early Recognition and the Permanent Arrest of the Disease." By Arthur Latham, M.A., M.D., Oxon., M.D., Cantab., F.R.C.P. Lond. Second Edition, pp. 224. London: Bailliere, Tindall and Cox. 1905; price 5s.

(b) "A Manual of Toxicology." By Albert H. Brundage, A.M., M.D., Phar. D., Professor of Toxicology in the Rhode Island College of Pharmacy. London: Bailliere, Tindall and Cox. 1904.

which may, without inconvenience, be carried in the coat-pocket and contains a great deal of useful information not only on toxicology but on many other subjects. There is a key to "Uranalysis," there are formulæ for freezing mixtures, and there is a table showing the order of eruption of the teeth, which it is suggested, may be found useful in determining the age of the patient. There are questions for "self-examination," some of them puzzling and by no means easy of solution. The information seems to have been collected from a variety of sources, and most of it is reliable. The directions for the treatment of cases of poisoning are in one or two places a little confused but, as a rule, they are practical and to the point. The author points out that sulphonal and trional may produce claret-coloured urine, but says nothing about hæmatoporphyrinuria, and gives no warning as to the gravity of the symptom. The work is well illustrated, and there are many coloured plates showing the *post-mortem* appearances of the stomach in poisoning by sulphuric acid, and other corrosive drugs. It contains in a condensed form much which cannot fail to prove helpful, especially in cases of emergency. There is a good index and this adds to its value.

INTERNATIONAL CLINICS. (a)

This volume of the fourteenth series of International Clinics is, like its predecessors very nicely got up as far as printing, binding, and illustrations are concerned. Like its predecessors also, however, its contents, as far as their value is concerned, are most valuable, but they show, perhaps, on the whole, a somewhat better selection than did the preceding volumes, and certainly more fully justify the term "international," since contributions from representatives of no less than five countries are included within it. In none of the numerous papers contained within it will the specialist or city medical man find much that he is not already acquainted with, but doubtless the busy country practitioner will derive both pleasure and information from the perusal of not a few of them.

Among those of most interest may be mentioned the paper by Parkes Weber and Watson, in "Chronic Polycythaemia with Enlarged Spleen," which they communicated to the Clinical Society of London early in last year. It constitutes a careful and thoughtful study of one of those interesting cases, and is of special value on account of its full autopsy report. The rather elaborate communication by Craig on the relation of the *amœba coli* to intestinal and hepatic lesions is also of interest, and of value as a confirmation of many previously held views, whilst mention may be made also of a fresh communication by Mons. Gaval on the "Dechloridation Treatment of Nephritis" in which he discusses the indications for that method of treatment, and quotes illustrative cases.

Medical News.

Royal College of Surgeons of England.

AN ordinary meeting of the Council was held at the College on Thursday last, May 11th, Mr. John Tweedy, President, presiding.

The Jacksonian Prize was presented to Mr. Herbert J. Paterson, F.R.C.S.

A report on the history and work of the laboratories of the two Royal Colleges was received from Dr. P. H. Pye-Smith, Chairman of the Laboratories Committee, and a vote of thanks was accorded to him for the same.

It was agreed to take steps with a view to prosecuting a person, to whose proceedings the attention of the Council had been called, for falsely assuming the title F.R.C.S.

It was decided to give an afternoon reception to the members of and visitors of the Atlantic Union, at some date to be selected by the President.

Mr. John Tweedy, President, was elected as a repre-

(a) "International Clinics. Volume IV. Fourteenth Series, 1905." Philadelphia and London: G. B. Lippincott Company.

sentative of the College on the Court of the University of Sheffield.

A vote of thanks was given to Mr. Thomas Bryant for some letters and a photograph of historic interest.

The following resolution, moved by Mr. Henry Morris, and seconded by Mr. Watson Cheyne, C.B., was carried, viz.:—"That it be referred to the Committee of Management to consider and report as to the desirability of treating chemistry, physics, and biology as subjects of preliminary education and of requiring that an examination in them should be passed before the recognition of the commencement of medical studies, and to further report as to the desirability of the two Colleges approaching the Universities and other examining bodies with a view to adopting a five-years' curriculum of professional study from the date of passing the Preliminary Science Examination."

A diploma for the licence in dental surgery was issued to Mr. Alfred Braithwaite Charlick, of Southport.

The following candidates, having passed the required examinations, were admitted members of the College, viz.:—Sydney C. Allen, Francis B. Ambler, Berkeley N. Ash, Ivor G. Back, Albert O. Bisson, Edward Brabazon, Richard C. Bright, Charles B. D. Butcher, Hector C. Cameron, Thomas A. Chater, George H. Cheyney, Charles St. Arnaud Coles, Reginald John H. Cox, Stephen E. Crawford, Victor A. Crinks, Claude H. Cross, Ashley S. Daly, David M. Davies, William L. Dickson, Percival A. Dingle, Cecil J. S. Dismorr, James S. C. Douglas, Arthur M. Dowdall, Stanislaus M. Dowling, Thomas W. N. Dunn, Watts Edmondson, John N. F. Fergusson, George Finch, Ernest V. Frederick, Kenneth F. Gordon, Harold E. Graham, Samuel L. Graham, George F. Hardy, Walter D. Hartley, Charles F. A. Hereford, Wilson H. Hey, Gilbert Holroyd, Eric C. Hood, Alfred W. Hooker, Charles W. M. Hope, Alfred S. Hosford, James B. Howell, Thomas M. Hughes, Cecil W. Hutt, Richard R. Huxtable, Charles Edward Iles, Algernon M. A. James, Frank A. Juler, Edgar N. Jupp, Frederick W. Kemp, Bernard W. Lacey, Llewellyn Llewellyn, Francis J. Loveday, Donald G. MacGill, Frank S. Machin, Thomas W. Maddison, Harold P. Martin, John C. Mead, William Miles, Henry Mills, Percy F. Minett, Basil E. Moss, Reginald C. Neil, Arthur B. O'Brien, Douglas C. L. Orton, Vladimir N. Ouranski, Percy R. Parkinson, Percival L. Pearce, Alan H. Pinder, Robert E. Pitts, Gordon C. Pounds, George Raymond, Arthur G. L. Reade, James D. Reid, Percy G. Reilly, Frank M. P. Rice, David H. Richards, Robert L. Ridge, John C. L. Roberts, Horace H. Rolfe, Gerald F. Rudkin, James E. Rutherford, Emil Schwarz, Harold E. Scoones, Harold M. Scott, William L. Scott, Timothy W. Sexton, Cyril A. Smallhorn, Armstrong Smith, Thomas Stordy, Samuel H. Sweet, Arthur B. Sykes, Edwin C. Tatam, George Thom, James D. Thomas, Louis C. Thompson, Arthur Toulmin, William S. Tresawna, John R. R. Trist, Rawdon A. Veale, William C. A. Ward, Walter J. Weston, Alfred G. Whitaker, Frank E. Whitehead, Augustus S. Williams, William P. G. Williams, David Wilson, Ernest D. Wolff.

Sir Patrick Dun's Hospital.

THE annual report of Sir Patrick Dun's Hospital, just issued, shows that it, like most of the general hospitals in Dublin, is in serious financial difficulties. The total expenditure last year amounted to £6,207, while the income, apart from legacies, was only £4,283. If some substantial legacies had not fallen in, the Governors would have had to realise the greater part, if not the whole, of the reserve fund of the hospital. During the year aid was given to 22,371 sick people, of whom 1,260 were intern patients. The Board intimate that unless a substantial increase takes place in their list of subscriptions this year it will be necessary to close some of the wards.

Jervis Street Hospital, Dublin.

THE annual meeting of the friends and supporters of Jervis Street Hospital was held on the 5th inst.,

the Lord Chief Baron in the chair. The report of the Managing Committee stated that 1,237 intern patients were relieved in 1904 at the moderate cost of £19 17s. 4d. per bed, while no less than 25,366 poor persons were attended to at the dispensary attached to the extern department. The total expenses for the year amounted to £5,935, whilst the sums received from the annual subscribers only amounted to £975 4s. 9d. The committee acknowledged, with thanks, bequests amounting to £1,222, without which sums it would have been impossible to maintain the hospital. They also thanked the Dublin Corporation for their generous contribution of £405 per annum. Deep regret was expressed at the loss the hospital sustained during the past year by the deaths of Dr. Austin Meldren and Dr. Cranny. The Lord Mayor, Bishop Donnelly, Mr. Lawrence Waldron, M.P., Rev. Samuel Prenter, Sir James Murphy, and Sir John Barry took part in the proceedings. Attention was drawn to the grave financial difficulties by which this ancient charity finds itself embarrassed.

Municipal Milk Depots.

THE Special Committee of the Fulham Borough Council appointed to consider a scheme for establishing municipal depots for the supply of sterilised milk has put in an unfavourable report stating that heavy loss occurred in connection with similar undertakings at Battersea, Liverpool and St. Helens.

The Royal University of Ireland.

THE Senate met on Friday last, May 12th. The secretaries reported the death since last meeting of the Right Hon. The Earl of Kenmare, K.P., M.A., a member of the Senate. On the motion of the Rev. Dr. Delany, seconded by Judge Shaw, a vote of condolence with the family of Lord Kenmare was passed unanimously. A report from the Clerk of Convocation was received of the election by Convocation of the following as members of Senate:—His Honour Judge Shaw, Dr. Anderson, Dr. Walton Browne, Dr. Leslie, Rev. Dr. Leitch, and Mr. Cuming. The results of the recent spring medical examinations were considered and awards made. A meeting of the University was afterwards held, at which the degrees of M.D., M.B., B.Ch., and B.A.O., were conferred. The names of the successful candidates were published in our last weekly issue.

Dermatological Society of Great Britain and Ireland.

THE annual general meeting of the Dermatological Society of Great Britain and Ireland will take place at 11, Chandos Street, Cavendish Square, W., on Wednesday, May 24th, at 4.30 p.m., Dr. Henry Waldo, President, in the chair. Professor McCall Anderson will deliver the oration, on "A Plea for the more General Use of Tuberculin by the Profession."

Trinity College, Dublin.

THE Post-Graduate courses at this College in medicine, surgery, gynaecology, diseases of the eye, throat, nose, ear and skin, and in anatomy, pathology, X-ray and cystoscopy, will commence on June 12th, and terminate on July 2nd. Further particulars will be found on reference to our advertisement columns.

Royal Colleges of Physicians and Surgeons of Ireland.

THE following candidates have passed the Fourth Professional Examination:—Georgina Whately Clarke, Florence Maud Mary Condon, Michael Timothy Donovan, Gerald Hugh Gallagher, Richard Trimble Gordon, William Kelly, Thomas Joseph Brooke Kelly, Joseph Aloysius Mescall, Alfred O'Reilly, Patrick Madden Sheridan, William John Trimble, John J. Vasquez.

IT is announced that a small committee, consisting of Sir Michael Foster, Dr. J. S. Haldane, of Oxford, and Dr. M. H. Gordon, is making a further inquiry into the ventilation of the House of Commons.

Notices to Correspondents, Short Letters, &c.

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

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 re-forwarding 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.

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.

DR. J. M.—The local newspaper did not reach us until too late for use in our present issue.

LAUREATE OF THE MEDICAL SOCIETY OF LONDON.

A CANADIAN correspondent writes us that "The New Practice," by H. A. Hare, M.D., of Philadelphia, Laureate of the Medical Society of London, is largely advertised in the American and Canadian journals, and asks us what the author's claim to be "Laureate of the Medical Society of London," implies in England, and whether such a title exists. Being unaware of the existence of the book or of the laureateship, we are unable to afford our correspondent the required information, possibly some of our readers might help us.

DR. F. (Grimsby).—The Education Committee make their own arrangement with their medical examiners, and there is no fee fixed by statute for the medical examination of defective children under the Act of 1899. The failure to find money to pay for skilled public services is usually a fatal flaw to the administration of any given measure.

A. F. H.—A Bill for giving security to Medical Officers of Health was talked of, and there was a rumour of taking steps by motion if not by Bill, in connection with the Board of Trade, of Companies trading for medical purposes.

RESEARCH.—Mr. Samuelson, Under Secretary of State for Native Affairs in Natal, who is intimately acquainted with native life, says he has never known a case of cancer among the natives. If not absolutely immune, it seems clear that among the uncivilised natives carcinomas is almost unknown: epithelioma is met with now and then, as well as sarcoma.

INSPECTOR (Cumberland).—Sir Patrick Manson advocates the use of tar in the treatment of ground itch of coolies. We believe it is freely used for natives working in Indian tea gardens.

G. F. S. (Brisbane).—The credit of really determining the nature of arrow poison rests with Thomas Heazle Park, the medical hero of the Emin Pasha Relief Expedition.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MAY 17th.]

ROYAL MICROSCOPICAL SOCIETY (301Harover Square, W.).—8 p.m.—Exhibition of Slides of the Orbitides. Paper:—Mr. D. D. Jackson: The Movements of Diatoms and other Microscopic Plants.

ROYAL METEOROLOGICAL SOCIETY (70Victoria Street, Westminster, S.W.).—4.30 p.m. Papers:—Mr. E. Strachan: Measurement of Evaporation.—Dr. J. Ball: Logarithmic Slide-Rule for reducing Readings of the Barometer to Sea-Level.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. M. Collier: Clinique, (Surgical). 5.15 p.m. Dr. D. Robinson: Hyper-secretion of the Vagina and Cervix Uteri.

CENTRAL LONDON THROAT AND EAR HOSPITAL (Gray's Inn Road, W.C.).—5 p.m. Demonstration: Mr. S. Low: Oro and Laryngo-pharynx.

THURSDAY, MAY 18th.

NEUROLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—8.30 p.m. Papers: Dr. E. F. Trevelyan: A Note on Tabes Dorsalis occurring in Husband, Wife, and Daughter.—Dr. C. E. Box and Dr. E. F. Buzzard: An Unusual Case of Combined Degeneration of the Cord associated with Anæmia.—Dr. T. G. Stewart: Some Points in the Diagnosis of Tumour of the Frontal Lobes.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique: (Surgical). 5.15 p.m. Mr. A. H. Tubby: Orthopaedic Surgery.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Lecture-Demonstration: Dr. H. W. Carson: Malignant Disease of Large Intestine.

FRIDAY, MAY 19th.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN (11 Chandos Street, W.).—Dr. H. Ashby (Manchester): Some of the Neuroses of Early Life. (Wightman Lecture.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. L. Paton: Clinique. (Eye.)

TUESDAY, MAY 23rd.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Dr. G. P. Chappel: Infantile Diarrhoea.

Vacancies.

Lister Institute of Preventive Medicine.—Assistant Bacteriologist to the Serum Department, Elstree, Herts. Salary £200 per annum, with furnished rooms. Applications to the Secretary, Lister Institute, Chelsea Gardens, S.W.

Administrative County of Somerset.—Consulting Medical Officer of Health. Salary £150 per annum. Applications to H. M. Bennett, Clerk of the Somerset County Council, Frome.

Devon County Asylum, Exminster.—Junior Assistant Medical Officer. Salary £125 per annum. Applications to the Medical Superintendent.

Cornwall County Asylum, Bodmin.—Junior Assistant Medical Officer.—Salary £135 per annum, with board, lodging, &c. Applications to the Medical Superintendent.

State Criminal Lunatic Asylum, Broadmoor, Crowthorne, Berks.—Junior Assistant Medical Officer. Salary £200 per annum, with furnished quarters, coals, gas, and attendance. Applications to the Medical Superintendent.

The Sidlaw Sanatorium, Auchterhouse.—Medical Superintendent. Salary £250 per annum. Applications to Wm. H. Blyth Martin, Hon. Secretary, City Chambers, Dundee.

Coventry and Warwickshire Hospital.—House Surgeon. Salary £100 per annum, with rooms in the Hospital, board, washing, and attendance. Applications to Ellis E. Crisp, Secretary.

County Council of Middlesex.—Napsbury Asylum, near St. Albans, Herts.—Second Assistant Medical Officer. Salary £220 per annum, with board and lodging. Applications to the Medical Superintendent.

Metropolitan Asylums Board, near Dartford, Kent.—A Male Senior Assistant Medical Officer. Salary £250 per annum, with rations, lodgings, attendance and washing. Applications at the Office of the Board, Embankment, E.C.

Norfolk County Asylum, Thorpe, Norwich.—Second Assistant Medical Officer. Salary £150 per annum, with board, attendance, quarters, washing, &c. Applications to the Medical Superintendent.

Appointments.

COURTS, D., M.B., O.M.Glasg., Assistant at Kingseat Asylum, Glasgow.

HINGSTON, CHARLES ALBERT, M.D., B.Sc.Lond., M.R.C.S.Eng., Honorary Physician to the Crownhill Convalescent Home, near Plymouth.

JUNSON, J. E., M.B.C.S., L.R.C.P.Lond., Honorary Assistant Medical Officer to the District Infirmary and Children's Hospital, Ashton-under-Lyne.

WALL, VIVIAN F., L.R.C.P., M.R.C.S., L.S.A., Honorary Anaesthetist to the Western Ophthalmic Hospital, Marylebone Road, W.

WATERFIELD, WILLIAM HENRY, L.R.C.P. & S.Irel., Chairman of the Children's Committee of the Devonport (Devon) Board of Guardians.

Births.

BIRD.—On May 18th, at Old Hayes, Sidmouth, the wife of Arthur C. Bird, M.R.C.S.Eng., L.R.C.P.Lond., of a daughter.

ORMEROD.—On May 11th, at Beauchamp Lodge, Wimborne, the wife of Ernest William Ormerod, M.D., of a daughter.

Marriages.

GARDNER-MEDWIN—COODE.—On May 11th, at St. Saviour's Church, Baling, Frank Medwin Gardner-Medwin, B.A., M.R.C.S., L.R.C.P., elder son of the late Joseph Gardner, of Folkestone, to Hilda Louisa Mary, second daughter of Worster Benson Coode.

STEVENS—HEAL.—On May 11th, at All Souls', Langham Place, C. H. Stevens, M.R.C.S., L.R.C.P., of Plympton, to Mary, elder daughter of Frank Heal, of Bedford Park, W., and the Inner Temple.

Deaths.

SMITH.—On May 10th, at Millford, Victoria Road, Sandown, Susannah, widow of the late John Smith, M.D., of Windsor, aged 73.

WINTER.—On May 11th, at Tangier, Leonard Bradbury Winter, of Fez, Morocco, youngest son of John N. Winter, M.R.C.S., of Kew Gardens and Brighton, aged 30.

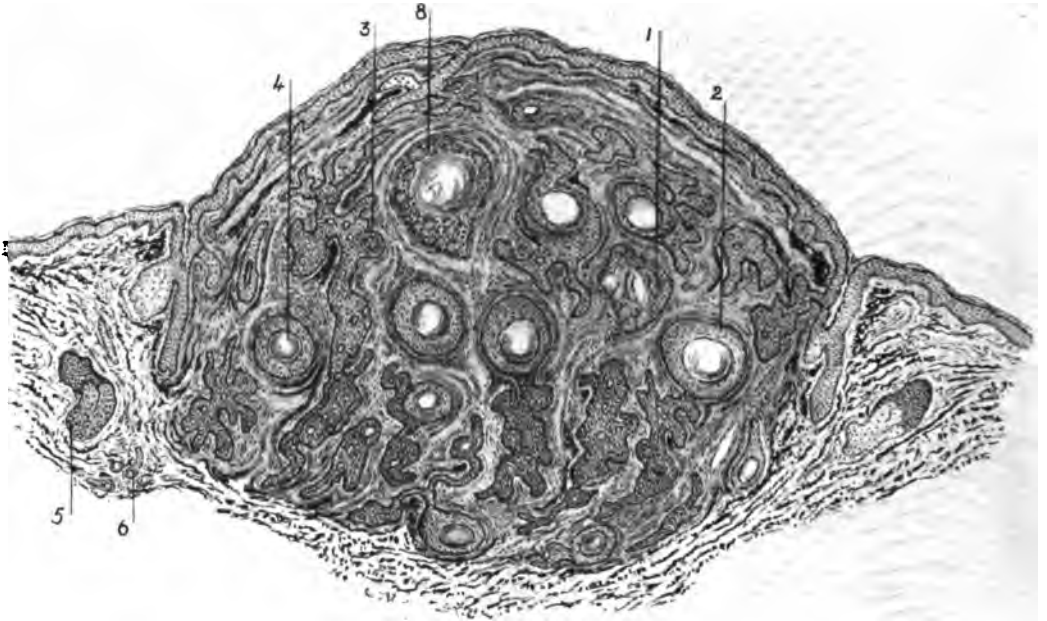


FIG. 1.

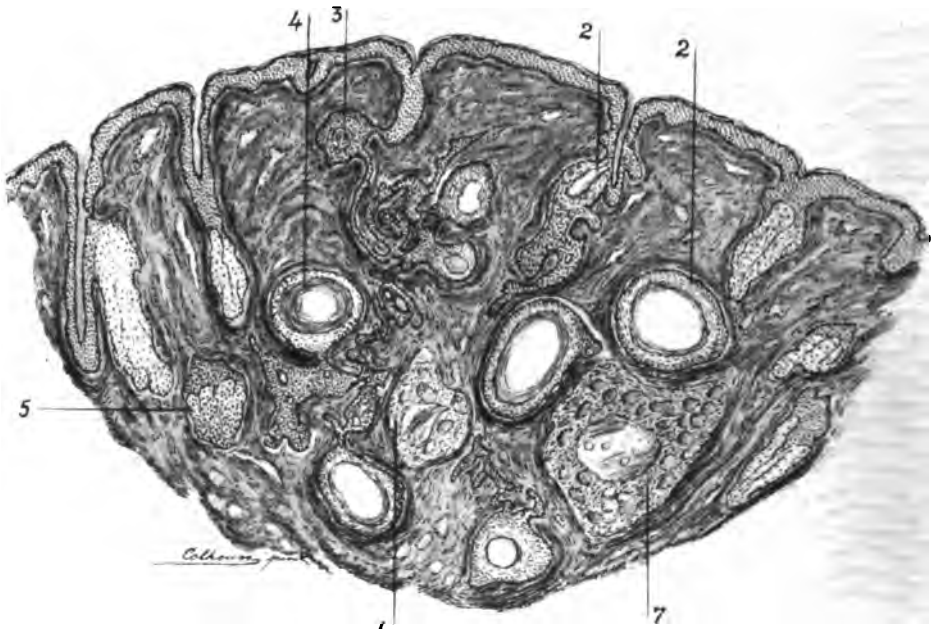


FIG. 2.

To illustrate Dr. Brimacombe's Paper on "Fibro-Cystic Sebaceous Celluloma."

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX"

VOL. CXXX.

WEDNESDAY, MAY 24, 1905.

No. 21.

Original Communications.

FIBRO-CYSTIC SEBACEOUS CELLULOMA.

By R. W. BRIMACOMBE, M.D.,

Assistant Pathologist, St. John's Hospital for Diseases of the Skin.

I HAVE preferred to describe the two following cases under the above title for the accompanying reasons:—

- (1) The connective tissue throughout the cutis has been converted into fibroid tissue.
- (2) The cystic degeneration of the sebaceous apparatus (sebaceous gland, sebaceous duct and hair-follicle).
- (3) The epithelial new growth involves the whole of the sebaceous apparatus and not a part of it, as formerly described.
- (4) Its non-malignancy.
- (5) And the title more correctly indicates the salient features histologically of this disease, which up to the present time has been known by such a formidable list of names, all more or less incorrect and therefore difficult of selection.

I shall refer only to a few cases reported by the more recent investigators, because I think with Hartzell "that all those cases which have been so lavishly named are varieties of one and the same affection, both from a clinical and histological point of view." Epithelioma adenoides cysticum (Brooke) is a very misleading name to designate this affection. Epithelioma is generally meant to infer, by most writers, a superficial cancer involving the skin or adjacent mucous membrane. Adenoma and adenoides cannot be applied to these cases, as the epithelial new growth in no way resembles the normal secreting structure of the gland. An adenoma is hypertrophy of the whole gland, whilst retaining its original structure. For the same reason, the multiple benign cystic epithelioma of Fordyce, a term adopted by other American dermatologists, is inappropriate. Acanthoma adenoides cysticum (Unna) does not identify in any way the condition one has to deal with. In Unna's own words "acanthoma" indicates those epidermic growths "with epithelial fibrillation," and under this name he includes several benignant epidermic growths. In these cases, however, there is no cellular fibrillation. The word acanthoma originated with Auspitz, who referred to all papillomata as distinct from cutaneous tumours, and later qualified it "as a growth of the prickle layer."

Clinically, my two cases resemble very closely those previously described. They are in different stages. The earlier is characterised by the presence of small dirty-white transparent tumours ranging from the size of a pin's head to that of a pea, whilst the larger and older tumours have a somewhat violet tinge, its smaller lesions are discrete, round and firm to the touch, the larger ones in some cases coalesce, feel almost elastic and are more or less flattened. These tumours appear on the fore-

head, nose, cheeks, chin and upper lip, and in the latter position have assumed definite lines. A central depression is well marked in some of the larger growths, and most of them contain a white milium-like body. They were first noticed about ten years ago when the patient was fifteen years of age. The condition is admirably shown on the accompanying block. In the other case (not illustrated) the disease is of older standing, and a rhinophyma is associated with the tumours, which more extensively cover the face and involve to a less degree the hands and arms. In considering these cases histologically I propose to adopt the three following heads:—1. Cysts. 2. Epithelial new growth. 3. Epithelial giant cell degeneration; because on taking a bird's-eye view of a microscopical section these three features appear most prominent. I must, however, mention that the epidermis is normal and the cutis shows atrophy of elastic tissue with merely an increase (no infiltration) of the spindle-shape connective tissue cells; and their conversion into fibroid tissue. The blood



vessels are atrophic and account for the dirty-white, pearly, hyaline condition of the tumours clinically. This

is in marked contrast to sebaceous adenoma, in which the glands are highly developed, not cystic, and the blood vessels increased, so that clinically the nodules are red and vascular.

(1) *Cysts*.—It is quite evident that the hair-follicles, sebaceous ducts, and sebaceous glands take part in the cystic degeneration, and not only the hair-follicles as stated by previous observers. It is true that the cyst formation in the sebaceous glands is slight, as compared with that of the hair-follicles and sebaceous ducts, and occurs only in those glands which have undergone epithelial giant cell degeneration, not in those occupied by epithelial new growth. This point is well shown in the plate showing the microscopical sections. It is numbered 1, and other figures in the following text refer to the same drawing. (1) In some few cases shreds of colloid material are seen to occupy these cysts. The cysts of the hair-follicles and sebaceous ducts show the hyaline structure of the epithelial cells internally, whilst externally they are surrounded by the new growth cells. (2) This is especially well seen in cross sections, and it is this hyaline condition of their stratum mucosum layer that enables one to recognise the hair-follicles and sebaceous ducts. The centre of the hair-follicle is filled up, in some cases, by the hair itself with pigment, (3) in others by colloid material. (4) Some of the larger cysts are empty, and this is probably to be explained by the falling out of the colloid material in the preparation of the specimen. It is the curious grouping, or perhaps, more strictly speaking, the large number of lanugo hair-follicles and sebaceous ducts which one would expect to find in tumours situated on the face and forehead, that has led some observers to describe "cell nests" present. I can find no "cell nests" as distinctive of malignant epithelioma.

(2) *Epithelial New Growth*.—As in the cystic degeneration so with the cellular new growth, it involves not only the hair-follicles but also the sebaceous glands and sebaceous ducts. These "cell masses and cell tracts surrounded by connective tissue," which have been described, now occupy what was originally the sebaceous gland. I have not found the sebaceous glands quite normal and independent of cell groups as stated by Fordyce, but on the contrary a microscopical specimen shows the secreting cells to be completely atrophied and their place occupied by these cell masses and cell tracts. Where there is any evidence of the presence of sebaceous gland, and this is only to a very limited extent, the secreting cells are becoming atrophied and are being gradually invaded by the new growth cells from the hair-follicle in connection with it. (5) In a later stage the whole gland becomes occupied by these cell masses and still later it takes on a peculiar tubular arrangement by the approximation of its marginal epithelium already converted into new growth cells. Consequently, although the secreting structure of the gland has disappeared, the marginal epithelium forming the circumference has enormously increased and the gland assumes a more or less collapsed condition. It is this tubular arrangement of the cell masses which has led to so much discussion and to so many divergent opinions, and is to be readily appreciated in a great measure by the "cutting on" of a sebaceous gland in the preparation of a microscopical specimen. It is only necessary to refer to a microscopical section of rodent ulcer, showing the sebaceous gland in sections and not as a whole, to see that the cell masses have a very close resemblance. But, whereas the cellular growth in rodent ulcer develops and increases, in these cases it undergoes epithelial giant cell degeneration. Again, if further proof is wanting that it is the sebaceous gland that is involved, and not merely a new growth in the cutis, the giant cell degeneration of the cell masses clearly indicates the outline of a pre-existing gland, surrounded by a band of dense fibrous tissue. This explains Brooke's "limitation of the growths." Whilst speaking of rodent ulcer, a differential diagnosis is readily made from these cases by, in the former, a greater sclerotic change in the connective tissue,

greater dilatation of the lymphatics and infiltration of round cells, plasma cells and mast cells. It is true in both cases (rodent ulcer and fibro-cystic sebaceous celluloma) the marginal epithelium of the new growth changes from the cubical to that of the cylindrical or spindle-shape type, and in each case takes the stain more deeply than the general mass of cells. To epithelioma they have no resemblance. I think there is no doubt the starting point of these new cells is in the hair-follicles and not in the epidermis, that is to say, their origin is from the papillary and prickle-layers of the hair-follicles. This is well-shown where the new cells are invading the sebaceous glands from the hair-follicles directly connected with them. (5) The papillary layer of the hair-follicle takes an early and most prominent part in this change, to be followed by that of the prickle layer, and this is seen in cross sections of hair-follicles and sebaceous ducts together with the tubular arrangement of the cell masses in the sebaceous glands.

Quinquaud, in his eruptive epithelial cystic celluloma, considers the hair-follicles and sweat glands normal. Jacquet and Darier, who thought these cells originated in the sweat glands, referred to these cases as epithelial adenomata, but subsequently abandoned the theory of glandular origin of the tumours. The sweat glands are quite free, the microscope showing them to be normal on either side of the cell masses, but in an atrophic state beneath. (6) This is probably to be explained by the fibroid tissue in the cutis. For the same reason can be attributed the spindle-shape character of the new cells, which are larger and stain more deeply than the normal epidermic cells.

(3) *Epithelial Giant Cell Degeneration*.—This very important feature, as far as I am aware, has been overlooked by all previous investigators. Giant cells are, however, readily demonstrated in what was originally sebaceous gland, and in most cases occupy nearly the whole of the gland space, surrounded or tied together by a deep band of spindle-shape connective tissue cells. These nodules have a definite hyaline appearance, due to the hyaline structure and grouping of the giant cells. (7) There can be no doubt the gland was originally occupied by new growth cells, as there is plenty of evidence of these new cells remaining, which have not undergone giant cell degeneration. These giant cells are of the epithelial type and are not due to infiltration, as in syphilis and lupus. The hair-follicles and sebaceous ducts in direct connection with the degenerated sebaceous gland lose their hyaline character, and the majority of their new growth cells are converted into a ring of giant cells surrounded by fibroid tissue, in the centre of which is colloid material. (8)

I have dealt with these cases principally histologically, because clinically they resemble in all respects those previously published. Although they are comparatively rare and a diagnosis clinically somewhat difficult, microscopical specimens showed one had to deal with a precisely similar condition to those formerly described under the numerous different titles, some of which I have enumerated. I look upon these cases as furnishing an example of a giant cell degeneration of an innocent character following a cellular new growth.

To Dr. Morgan Dockrell and Dr. Eddowes, under whose care these patients originally came, I am greatly indebted for so kindly allowing me access to the necessary material. Of the more advanced case Dr. Eddowes showed clinical and microscopical drawings at the last meeting of the British Medical Association held at Oxford, under the title of *acanthoma adenoides cysticum*. Dr. Eddowes claims to have found what appears to be a minute streptococcus in the hair-follicles, and might therefore be a possible cause of this interesting disease. It can, however, be readily conceived that the contents of the hair-follicles would form an excellent medium for micro-organisms.

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TRANSFUSION:

SUBCUTANEOUS AND INTRAVENOUS, IN GYNÆCOLOGICAL PRACTICE. (a)

By GEO. H. BURFORD, M.B., C.M.ABERD.,

AND

JAMES JOHNSTONE, M.D.ED., F.R.C.S.

DR. BURFORD gave a brief history of the evolution of blood transfusion in England from the experiments of Lower and King, communicated to the Royal Society in 1666, to those of Schäfer, enumerated in a report to the Obstetrical Society in 1879. The practice of saline transfusion, initiated by Goltz and legitimized by William Hunter, was briefly sketched and mention made of the work of Jennings and others.

In dealing with the physiological aspect of the subject of our paper, a few words may be said as a historical retrospect and lead up to the most recent views on the physiology and physics of transfusion. For many years, up to quite a recent date, it was held that in the blood was the life of the body, and consequently that to restore vitality under certain conditions it was necessary to inject some of the vital fluid whether from man or animal. That the added fluid should be blood was an essential idea. This was supported by the teachings of physiology up to a few years ago, when the view was held that blood transfusion after hæmorrhage was intended to fulfil two wants in the impoverished body—namely, the want of hæmoglobin to carry the oxygen, and the want of plasma to nourish the impoverished cells. Further investigation, however, showed that the red corpuscles introduced into a new home had a very short life, becoming disintegrated, destroyed, useless as oxygen carriers and ultimately leaving the body by the excretory organs. Only for a very short period might they be presumed to maintain their physiological rôle and confer an ephemeral benefit on the receiver.

This phenomenon of destruction of red corpuscles or hæmolysis is familiar enough, and readily demonstrated when the blood of one animal is introduced into another of different species. But the same holds good, though perhaps in a minor degree, when the animals concerned belong to the same species. A fate similar to that of the red blood corpuscles befalls the albumens of the blood when transfused. They do not fuse and form part of the plasma of the receiver, but while maintaining a brief separate existence are ultimately destroyed and broken down to form additional effete matter, thus increasing the amount of work thrown on already enfeebled and over-burdened excretory organs. Thus it was discovered that the chemical and nutritive properties of the blood failed to act up to the expectations of the physiologist and the surgeon.

Attention was then turned to the physical properties of transfused fluid and its physical effect on the apparatus of a depleted circulation. As the recording instruments of the physiologist became more simple, delicate and accurate, it was found that blood pressure in the vessels of the circulation is maintained at a certain height, with rhythmical variations, which in health are comparatively slight. A very large quantity of blood may suddenly be withdrawn from the circulation and yet, by an adjusting mechanism, the blood

pressure, which may have temporarily fallen, regains its normal level in an amazingly short time. This is accomplished by increased peripheral resistance due to the contraction and lessened calibre of the smaller blood vessels. These are under the influence of the vaso-motor centre, and loss of blood pressure acts as a stimulus to their contractile mechanism. Thus the lowering of blood pressure is up to a certain point completely neutralised by the compensating adjustment. It is only after very severe hæmorrhage that this relation between the vessels and the amount of fluid they contain is disturbed. In such cases the pressure falls rapidly and suddenly, and death will ensue unless means be taken to meet the threatened failure of the circulation. It is generally accepted by experimental physiologists that, in cases where the loss of blood has been severe or where the bulk of the blood has found its way into the abdominal vessels owing to paralysis of the vaso-motor centres, the effect is to deplete the general circulation, including the large veins which supply the right side of the heart. The heart has thus a diminished supply of blood. To maintain the proper working of the mechanical apparatus in the heart and also to maintain rhythmic muscular contraction, a certain amount and regular supply of fluid for the chambers is an absolute necessity. When the amount falls below this, the result is interference with the output of the heart, ending in cardiac failure.

This, therefore, may be taken as the physiological explanation of the phenomena which are unfortunately to be met with during or after surgical operations involving much loss of blood or complicated with the group of clinical symptoms which we know as shock. Both the conditions of hæmorrhage and shock are evidenced by a fall in the blood pressure. If the blood pressure falls below a certain point it indicates such a diminution of the heart's output as to render further action of the heart impossible. From this explanation it is easy to see how hæmorrhage involving much loss of volume of blood will produce cardiac failure. A word or two may be said, however, to indicate the relation between shock and failure in blood pressure. Physiology teaches us that when the vaso-motor mechanism of the abdominal contents are prevented from acting, the blood vessels, small and great, may so dilate that the animal is "bled into its belly," with such a fall in the general blood pressure as to be incompatible with further action of the heart and life. The converse is also true. If the splanchnic vessels are clamped and the splanchnic circulation be thus shut off from the general circulation there is a rise in the blood pressure with a fall when the clamp is removed. Some surgical operations, especially those affecting large nerves and certain structures, such as peritoneum, testicle, &c., are followed by inhibition or paralysis of the whole vaso-motor system, causing immediate fall in the blood pressure. This is well illustrated in Crile's work on "Surgical Shock," where tracings are given to illustrate the effect on the blood pressure of incising the skin of the abdomen, manipulation of the peritoneum, exposing the intestines, &c. A very interesting experiment shows that the fall produced by exposing the intestines is replaced by a rise when the splanchnic circulation is clamped off and that area of possible diminished resistance rendered unavailable for loss of blood from the general circulation.

The immediate result of interference with some other organs is a rise in the blood pressure—viz., manipulation of the uterus, of the ovaries, dilatation of the vagina and particularly of the anus. But as has been clearly exemplified by Crile's experiments and forcibly drawn attention to in his conclusions, the result of action is reaction and fatigue. Repeated calls for rise in the blood pressure result in ultimate exhaustion of the vaso-motor mechanism and ultimate low pressure.

PATHOLOGICAL CONDITIONS NECESSITATING SALINE INFUSION. DEFINITION OF COLLAPSE AND SHOCK.

Collapse, as defined by Crile ("Surgical Shock," p. 150), is immediate depression or death from injuries or

(a) Paper read before the British Gynecological Society, May 11th, 1905.

operations due to one or more of the following factors: (1) cardiac; (2) respiratory; (3) hæmorrhage; (4) vaso-motor.

Of these the factor which concerns us most in gynæcological and obstetric work is hæmorrhage, though excessive asthenia as affecting cardiac and respiratory mechanism is not to be lost sight of. Hæmorrhage, to cause collapse, must be excessive and is generally from large venous trunks.

Surgical shock, as opposed to collapse, "is mainly due to the impairment or breakdown of the vaso-motor mechanism, but all the factors referred to as causing collapse may add to shock. It would seem that in the fatal cases of shock, and in the conditions of most profound shock there is a condition of either total paralysis of the walls of the smaller vessels or its equivalent, allowing a fall of blood pressure below the standard necessary for effective cardiac action."

That the heart is not exhausted and is not the principal factor in the production of shock is a just conclusion based on a well-known physiological experiment; for the mammalian heart has been kept beating for many hours after removal from the body; also, when allowed to "run down" almost to the point of ceasing, it can be incited to further activity when a suitable fluid is provided for it to act on. The various experiments and arguments relating to this subject cannot be referred to here for want of time.

LOWERED BLOOD PRESSURE THE LEADING FEATURE OF HÆMORRHAGE AND SHOCK.

Our object thus far in prosecuting these physiological data and conclusions and in trespassing on your patience is to point out an essential factor common to hæmorrhage and shock—namely, fall in blood pressure, due, in the former, to direct depletion of blood and in the latter to diminished peripheral and splanchnic resistance. If it is possible to restore the blood pressure, we may hope to save our patient. Transfusion of blood is the means which has been adopted for this object, the transfused fluid acting not in virtue of its physiological or pro-carrying property but on account of its volume and bulk in filling out the depleted heart and vessels to a point when the circulation can be maintained satisfactorily.

Transfusion of blood has not fulfilled its expectation, and since its introduction the operation has been attended with difficulties, which still seem insuperable even to modern advances in technique and knowledge. Various substitutes have been suggested, especially milk, the blood of other animals, and normal saline solution. The two former have been ruled out of court as being useless and even harmful. The substitute which has come to stay is normal saline solution. In emergency, the infusion of even ordinary water has been followed by results as successful as any obtained after transfusion of blood. Bulk for bulk, pure blood should have certain advantages over normal saline solution, free from organic constituents. It probably possesses a certain physiological value as well as a physical value inasmuch as blood, being the normal content, should have a greater and more immediate effect in restoring the tone of the vaso-motor centres. But these problematical advantages are more than neutralised by the other and still greater disadvantages, viz: (1) The difficulty of obtaining blood in sufficient quantity or with sufficient rapidity; (2) the difficulties and dangers attending the transfusion of blood both to giver and receiver, of which clotting is the principal; (3) the doubtful value of the transfusion whether hæmogenic or physical.

The principal advantages of normal saline fluid are:—
(1) It does not destroy the physical, chemical, or physiological character of the blood of the receiver.

(2) It has no action on the red blood cells, to which it is isotonic. Their value is not impaired.

(3) It is readily obtained and easily prepared. It necessitates no "giver." It is easily manipulated.

(4) The fluid and the process of infusion is free from danger to the receiver.

(5) The quantity may be varied at will, and repeated, if necessary.

Experimental evidence is not wanting to show the beneficial effect of saline infusion in restoring blood pressure and vitality generally, and in this connection we would again make mention of the most valuable contribution of Crile. In his "Surgical Shock," p. 89, is given a tracing to illustrate failure of respiration and heart, followed by resuscitation with the combined effect of artificial respiration and saline infusion. The heart had ceased beating and was caused to resume action after a quiescence of 63 seconds, artificial respiration alone being of no avail.

Crile also gives in a table the summed results of saline infusion in various experiments, to show the rise of blood pressures, portal, general, and venous. It is interesting to compare these sustained results of saline infusion with the short rises in blood pressure induced by supra-renal extract from which more therapeutic value might have been expected, owing to its action on small blood vessels through the agency of the vaso-motor apparatus. As regards the height from which the solution was allowed to flow, Crile found there was no direct ratio between the elevation and the rise in blood pressure. Varying temperatures of the fluid referred to caused no uniform or corresponding difference in blood pressure. When the solution was cold the heart beats were diminished and strokes longer. Hot saline produced the opposite effect.

To quote Crile, "The effects of saline infusion were almost wholly mechanical and physical, within a reasonable range they were independent of variation in temperatures, rate and flow, height above animal and the vein into which it was introduced." "Where blood pressure had been lowered by reasonable hæmorrhage alone, saline infusion promptly restored it. Normal saline solution is effectual in shock in proportion to the impairment of the vaso-motor mechanism."

The limitations of the effect of normal saline solution must now be apparent—(1) If the peripheral resistance is lost ("break down" of the vaso-motor mechanism, that is to say, fatal shock) no amount of infusion can do more than temporarily or partially restore the lost blood pressure, and death is inevitable. (2) If the shock is much increased by regional accumulation of blood (so-called intra-vascular hæmorrhage), as in operations in the splanchnic area, infusion may be effective because the peripheral resistance is still present. The vaso-motor mechanism has not gone into resolution. (3) If hæmorrhage complicates shock and the vaso-motor mechanism is intact, infusion is effectual.

A report of twenty-five cases, post-operative and puerperal, was submitted, in which transfusion of a normal saline solution had been employed. In the post-operative cases where the indications were those of shock or hæmorrhage the cases almost uniformly recovered. But where the indications were those of sepsis the transfusion of normal saline was uniformly of no avail. Among the obstetric cases one of urobilinuria during pregnancy was cited where transfusion also proved useless, and one of puerperal hæmorrhage during acute mania, where the procedure was successful. The object of normal saline transfusion was the single one of raising defective blood pressure. The best time for transfusion was stated to be during the course of operation. The quantity of fluid used varied, being in one instance, as much as seven pints, by the intravenous method, at one sitting. The comparative results of (1) physiological and (2) therapeutic transfusion procedure were given; and the authors' compact instrument for intravenous or subcutaneous transfusion demonstrated.

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:—J. B. Bradley, J. A. Davies, R. J. O. Harley, J. W. Rollings, J. L. Schilling, I. C. Thornburn, J. A. R. Wells, and R. W. L. Wood.

"RHEUMATIC" AFFECTIONS OF THE EYE (a)

By SYDNEY STEPHENSON, M.B., F.R.C.S.
EDIN.

Surgeon, Evelin Hospital, &c. &c.

DEFINITE rheumatic affections of the eye are, in my experience, more often heard of than seen in actual practice. In fact, the word "rheumatic" is a legacy from ancient days, and even at the present time is often employed simply to cloak our ignorance of the essential nature of some diseases of the eye. At the same time certain ocular affections are undoubtedly of rheumatic origin, the best-known, perhaps, being rheumatic irido-cyclitis. A few years ago Dr. David Walsh propounded a theory that certain skin affections were accounted for by the excretion or attempted excretion from the body of irritants of various kinds, such as drugs, micro-organisms or their products. It occurred to me (b) that that explanation, if correct, should apply all round to organs concerned in excretion, of which the eye is one. Now almost all the general ailments capable of causing inflammation of the iris and ciliary body (it is scarcely scientific to speak of those structures apart from one another) are intimately associated with, if not actually caused by, micro-organisms. That fact will be disputed by none as regards syphilis, gonorrhœa, tubercle, leprosy, influenza, and relapsing fever. If the bacterial origin of rheumatism be admitted, then perhaps the commonest cause of irido-cyclitis would fall into line with the rarer causes mentioned, for it must be remembered that the ciliary body contained glands which, according to the researches of Mr. E. T. Collins, were engaged in the secretion and elaboration of the aqueous humour. The position might be stated in terms of a syllogism as follows: Most inflammations of the iris and ciliary body are dependent upon a constitutional ailment; a majority of these ailments are of bacterial nature; therefore, most forms of irido-cyclitis result from the action of micro-organisms. It was suggested as possible that the immediate cause of these particular inflammations might be sought in the vicarious glandular excretion of the microbes or their products circulating in the blood or other nutrient fluids of the body. At the time spoken of, the bacterial origin of rheumatism, although suspected by certain acute observers, had not attained its present solidarity. Since then Drs. Poynton and Paine had isolated from the lesions of acute rheumatism a minute diplococcus (1900). Not the least interesting result obtained by those workers was the experimental production of iritis by the injection of a pure culture of their "diplococcus rheumaticus" into the auricular vein of rabbits. The animals died of heart disease, and in the cloudy fluid in the anterior chamber of the affected eyes, Drs. Poynton and Paine found the causative organisms. A culture from the fluid when injected into another rabbit gave rise to chronic arthritis (*Ophthalmoscope*, October, 1903). The rheumatic origin of certain cases of irido-cyclitis has therefore been established on both theoretical and experimental grounds. Briefly, acute rheumatism, at all events, is now generally

looked upon as caused by a specific bacterial infection. It is an undoubted fact that many patients affected with rheumatic irido-cyclitis were influenced by anti-rheumatic remedies, especially by aspirin, given in liberal doses (grs. xv to xxx) every few hours. In my experience, aspirin is by far the most valuable remedy in such cases, apart from local treatment by atropine, heat, and, if necessary, leeches. Its analgesic powers are pronounced.

For my own part, I confess to being somewhat sceptical as to palsy of the ocular muscles due to rheumatism. Patients afflicted in that way often develop serious nerve lesions later, more especially insular sclerosis or tabes dorsalis.

With regard to the two other affections of the eye—conjunctivitis and episcleritis—now and then associated with rheumatism, both are in my experience somewhat rare. The conjunctivitis often passes unrecognised in so far as regards its etiology, although it presents certain clinical features almost peculiar to itself. In the first place it is seldom accompanied by appreciable discharge, such as is the rule in ordinary ophthalmia. Then it is apt to come on suddenly after exposure and to disappear as suddenly.

Again, the redness is practically limited to the ocular conjunctiva and the sclera beneath, particularly to that exposed in the palpebral fissure, when the eyes were open on either side of the cornea. This form of disease presents a close clinical likeness to the so-called metastatic conjunctivitis and scleritis found on rare occasions in association with urethral gonorrhœa, also a micrococcal disease. Lastly, it is in many cases definitely controlled by aspirin, administered in milk or lemonade, in doses of xv or xxx grains three or four times a day. The other malady—episcleritis—that is, peculiar purplish nodes of the sclera which appeared under the ocular conjunctiva, had been for many years regarded as of rheumatic origin. In some cases that is undoubtedly so. The malady is apt to relapse again and again, but many cases can be quickly checked by applying calomel locally and administering aspirin internally.

SIMULTANEOUS ECTOPIC GESTATION

IN BOTH

FALLOPIAN TUBES (a)

By GEORGE H. BURFORD, M.B., C.M.ABERD.

THE case (specimen exhibited) was that of a married woman, æt. 33, under the care of Dr. Sandberg, of Streatham, who referred the patient to Dr. Burford on November 28th, 1904. The clinical history showed that she had a normal parturition twelve years ago; two years later a premature labour occurred with adherent placenta. Several miscarriages took place in the ensuing years, and the last about three years prior to the present date. Since this latest miscarriage she had been perfectly regular, the last normal period commencing on September 7th, 1904.

In October the menstrual period was wanting, and late in that month, and during November, a sanguineous daily discharge, now lighter and now darker in tint, had persisted up to November

(a) A contribution to the Discussion on Rheumatism which took place on April 13th at the meeting of the Association of the Diplomates in Scotland.

(b) *Lancet*, February 29th, 1896.

(a) Paper read before the British Gynæcological Society, May 11th 1905.

28th, the date of consultation. During this hæmorrhagic term, she experienced constant pain, day and night, sometimes with acute exacerbations. There had been no definite crises of collapse, and the occasional acute seizures of pain were readily and safely tided over. No shreds or membranous patches had been seen in the vaginal flux. Examination now showed diffused abdominal tenderness below the umbilical zone. The percussion reaction was ill-defined, and no definite area of dulness was demonstrable. *Per vaginam* the uterus was drawn to the right side, not freely movable, enlarged, as in chronic sub-involution, and flanked by a diffuse inelastic deposit, mainly on the left side, distributing itself in less degree behind and to the right.

The diagnosis seemed to leave little to seek, and she was at once sent into hospital. The following day, while in bed, symptoms of internal hæmorrhage suddenly occurred, and the condition being critical the abdomen was opened without unnecessary delay. A small quantity only of recent clot presented itself, while the pelvis was roofed over by dense omental and intestinal adhesions.

Breaking through these, some handfuls of clot and a good deal of fluid blood were removed, and an intimately adherent mass about the size of an orange enucleated with difficulty. This was the left gestation sac, and perpending from it was a foetus still alive. Further search revealed a tubal swelling of less dimensions and of firmer consistence on the right side, which on removal proved to be another gestation sac with another foetus plainly visible. The most recent hæmorrhage had been from the left side. Transfusion to the extent of 2½ pints was carried on during operation. The patient made an unbroken recovery.

The specimens were submitted to the Clinical Research authorities for report, which was as follows:—"These specimens consist of the parts removed by operation and obviously represent two ectopic gestation sacs with contained foetuses. The right sac consists of the very much thinned-out Fallopian tube with the gestation sac in its ampullary extremity. The tube wall itself is thinned out until it measures about 5 to 1 millimetre in thickness; but is everywhere lined by a considerable layer of blood clot. The tubal sac measures 4 cm. at its widest part and is filled up with blood clot to the extent of about two-thirds of this measurement. The rest of the sac is occupied by the foetus. The fimbriated extremity of the right tube is opened up, and the opening measures about 8 mm. in the preserved specimen. The uterine extremity as such cannot be recognised. Near the fimbriated extremity the ovary of this side is firmly adherent, and contains a recent corpus luteum, which can be seen in the section of the sac. From this description it will appear that the specimen represents a tubal pregnancy which has been converted into a mole by hæmorrhage, and that probably hæmorrhage has also occurred into the peritoneum through the open fimbriated extremity. The foetus in this right sac measures 38 mm. from the top of the head to the lowest point of the breech.

"The specimen removed from the left side has much the same characters, but only a few thinned-out portions of the tube remain attached to it. It is a tubal mole measuring 4 cm. in breadth

and 5½ cm. in length, contains more than half its dimensions of blood clot and obvious chorionic villi, the rest of the sac containing the foetus. The foetus in this sac measures 41 mm. in length from the top of the head to the lowest point of the breech.

"From the measurements of the foetuses of the two sides 38 and 41 mm. respectively, it would seem that they must be of approximately the same period of growth, and if not actually conceived at the same time must have been very nearly so. The ages of the foetuses corresponded approximately to eight weeks.

"The smaller foetus is very macerated, and so may be regarded as having been at one time more nearly the same size as the larger one, which is quite well preserved."

At a meeting of the Vienna Obstetrical Society, reported in the *Centralblatt f. Gynäkologie*, No. 2, 1905, Professor Schauta, dealing with the subject of simultaneous bilateral tubal gestation intimated that there were only four recorded cases in literature. Professor Weinlechner mentioned a fifth, one of his own.

Clinical Records.

A CASE OF DOUBLE SENILE CATARACT IN A MAN, THIRTY-FOUR YEARS OF AGE.

Under the care of DR. FORBES H. WOLFE.
Tighnabraich, Kyles of Bute.

N. B., æt. 34, a joiner, came to consult me in August 1898. He complained of inability to see with the right eye. The dimness of vision had come on rapidly during the past few months and, on inquiry, I found that he had sustained a severe blow on the right side of the head from a falling beam, and it was from that time that he dated the dimness of vision. The left eye was perfectly normal. His mother had been blind from cataract for several years before she died. On account of his age and the history of injury and there being no lenticular trouble in the left eye, I regarded it as a case of traumatic cataract. I sent him to the Eye Hospital for operation, where the lens was removed by the usual method for removing a soft lens—*i.e.*, introducing a broad lance through the cornea into the lens substance, depressing the scleral margin of the wound, and thus getting rid of the lens substance. On examination some time after this operation I found that as regards the restoration of vision no good had resulted. As is frequently the case a very tough capsule had remained, which completely blocked up the pupil.

As the sight of the left eye was quite normal I thought it as well to leave things alone in the meantime; but in March, 1903, he again came to see me, and complained of some dimness of vision in the left eye. On dilating with homatropin I found that there was a commencing lenticular opacity of the left eye, and so I then tried to lacerate with a stop needle the capsule in the right eye but, owing to its extreme toughness, without any success. I therefore waited for a few days and again tried, this time with Demarres' canula forceps and minute scissors. This time I was successful in lacerating the capsule and removing a portion of it. The result was good vision.

The lens of the left eye gradually became more opaque until, in February 1905, I considered it ripe for extraction. On February 16th, I performed an iridectomy downwards and three weeks later I extracted the lens, making the corneal incision downwards close to the scleral junction and lacerating the capsule very freely with a cystotome. The capsule came out in one piece. The result is good vision.

Dressing consisted of strips of adhesive plaster to both eyes for two days, dry surgeon's lint and a fixed light bandage. On the third day the adhesive plaster

was removed and both eyes covered with dry lint and bandaged. On the fifth day only the eye which had been operated upon was covered. In twelve days the dressing and bandage were dispensed with, only a shade being worn when the light was bright. Healing went on without a hitch and the patient did not complain of a pain of any kind during the whole process.

Vision in both eyes at present is represented by V. R. = $\frac{1}{2}$ c + 11D = $\frac{1}{4}$; c + 15D reads Jaeg. No. 1. V. L. = $\frac{1}{2}$ c + 11D = $\frac{1}{4}$; c + 14D reads Jaeg. No. 1.

I think that this result shows that a preliminary iridectomy makes the operation of extraction of the lens easier, besides giving more space for the accouchment of the lens and thus avoiding bruising of the iris and cornea.

This case is an illustration of how senile cataract may develop in early adult life.

The above patient can now follow his occupation of a master joiner, draws his own plans, and can with ease read the smallest print.

Transactions of Societies.

ROYAL ACADEMY OF MEDICINE IN IRELAND. SECTION OF PATHOLOGY.

MEETING HELD FRIDAY, MAY 5TH, 1905.

PROFESSOR E. H. BENNETT in the Chair.

FRACTURES OF FIRST COSTAL CARTILAGE.

PROF. E. H. BENNETT presented a note on fracture of the cartilage of the first rib, illustrated by the exhibition of some six specimens of the injury. He dwelt particularly on the fact that in a majority of the cases the individuals had been females not likely to have been during life engaged in very heavy labour such as might be assumed to cause new or false joints in the cartilage, and that the recent fractures corresponded in all pathological details with fractures of the cartilages lower down in the chest.

DR. T. G. MOORHEAD asked how frequently Prof. Bennett had found a false joint, and also whether he had ever found a synovial cavity.

Prof. BENNETT replied by showing a specimen which illustrated an attempt at the formation of a false joint.

ANOMALY OF CARDIAC VALVE.

DR. MOORHEAD exhibited a case of anomaly of the mitral valve. On the ventricular aspect of the large anterior cusp a small foramen with smooth edges was present which led into a sac about one-third of an inch in diameter. The site and appearance suggested a valvular aneurysm, but the presence of muscular tissue in the wall, the absence of fibrin, and the smooth endothelial lining precluded that view.

TUBERCULOUS DISEASE OF CÆCUM, APPENDIX, AND ILEUM.

DR. R. ATKINSON STONEY showed a specimen of above removed by operation from a female, æt. 23. A tumour was found in the right iliac fossa, freely movable towards the middle line, to a less extent in an outward direction, but not either upwards or downwards. Patient complained of chronic constipation and occasional colicky pains. There was marked hyperæsthesia of the eleventh dorsal area of right side. At operation, a thickened band was found round ileum, one and a half inches from cæcum. The cæcum itself was large, nodular, and thickened. The diseased parts were removed and a lateral anastomosis performed. On opening the specimen a stricture with a diameter of half an inch was found in ileum, the cavity of the cæcum was almost obliterated, and a second stricture was found in the commencement of the colon, with a diameter of a third of an inch. No ulceration of mucous membrane was found microscopically, and the specimen was thought to be malignant. Some glands were found enlarged behind the cæcum. When examined microscopically both the

tumour and the glands were found to be infected with typical tubercle.

DR. W. J. THOMPSON said the specimen was unusual and interesting, and congratulated Dr. Stoney on the successful result of the operation.

DR. KIRKPATRICK said that during the past winter session he had seen two cases of tuberculous disease of the cæcum, both successfully treated by operation. In one case, after removal, the specimen was considered to be malignant, and it was only after very careful microscopic examination that the diagnosis was finally established. This bore out what Dr. Stoney had said. He thought the conditions could not be so rare as Dr. Stoney would lead them to believe, as this was the third specimen he himself had seen during one winter session.

DR. STONEY, in replying, said that he was sorry he had given the impression that tuberculous disease of the cæcum was a rare condition. Indeed, two London surgeons had lately published the results of eighty-four cases.

RECRUDESCENT ULCERATION OF STOMACH.

DR. W. J. THOMPSON stated that the specimen exhibited was taken *post-mortem* from a patient, æt. 29, clerk by occupation, who was admitted to Jarvis Street Hospital on February 21st last. He had contracted syphilis five years ago, and for two or three years previously had been drinking heavily. While under special treatment for about one year he ceased taking alcohol. Since then he drank freely. For the past six months he had drunk rapidly. Physical examination showed heart to be enlarged and organically diseased, also enlarged liver, dilated stomach, peripheral neuritis, and albuminuria. At the *post-mortem* examination the stomach was found enlarged, with a well-marked contraction near the pylorus. On opening it there were seven ulcers (two as large as a sixpence) in the region of the pylorus. These ulcers were on the cicatrices of two very large ulcers. Prior to death, patient showed practically no sign of gastric ulceration.

CONGENITAL SARCOMA OF THE EYELID.

MR. ARTHUR BENSON and DR. H. C. MOONEY showed a tumour removed from the upper eyelid of an infant, æt. 17 days. It was then the size of a small walnut. There was no family history of any form of malignant growth in either parent. At birth it was the size of a split pea, situated in the centre of the left upper eyelid. It was darkish in colour and somewhat resembled a hæmatoma. It changed little for a week and then grew rapidly. It was lobulated, very elastic in feel, and had entirely lost its dark look, and more resembled a cyst in feel and appearance. Three weeks afterwards recurrence took place in the neighbourhood of the wound; also over the malar bone and in the orbit. A second operation failed to eradicate it, and a sub-maxillary gland enlarged, also one in the axilla. The orbital tumour was, after three months, the size of a small potato, and similar in character to the original growth removed. Sarcomata of the eyelid, they said, were rare, and congenital unpigmented carcinomata of the eyelid had not before come within their knowledge. The tumour, irregularly oval, measured 25 mm. by 20 mm. by 15 mm. One section was creamy white, with small signs of vascularity. The skin removed with tumour was non-adherent, and under the microscope showed no signs of infiltration. Sections of the tumour showed nothing unusual, being a mixed celled, non-pigmented sarcoma with few blood vessels, but with a fair number of large dilated empty spaces, the walls of which seemed to be composed of the compressed surrounding tumour cells. Primary sarcoma of the lid is rare, about fifty cases having been reported, many of which were pigmented. As far as can be ascertained this case is the only one of congenital sarcoma of lid recorded.

DR. W. J. THOMPSON said he had seen the case shortly after birth. The tumour looked then like a small hæmatoma. The skin over it was freely movable, and its base seemed firmly attached to the eyelid. For a week afterwards there was an advance in size, and then it began to grow rapidly.

BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD THURSDAY, MAY 11TH, 1905.

DR. WILLIAM ALEXANDER, President, in the Chair.

SPECIMENS.

A SPECIMEN of Ectopic Gestation, simultaneous in both Fallopian tubes, was shown by Dr. George Burford. (His description will be found on p. 533.)

The PRESIDENT remarked that the specimen shown was a very rare one and he could not recall having seen a similar one.

Dr. ROUTH said it appeared that the gestation had occurred in both tubes at the same time. He believed that double gestations were extremely common in America, but probably that was due to another cause.

ABNORMALITY OF THE INTROITUS.

Dr. MACNAUGHTON-JONES showed with the epidiascope a deformity of the introitus, consisting of a prolongation forwards of the perineum, instancing two cases in which he had met with it. In one of these a decree of nullity of marriage had been obtained. He looked upon it as a primal step in the evolution of female hermaphroditism. Here he had resected the occluding fold, closing the wound by Michel's instrument and clamps. It had healed by primary union.

DOUBLE PYO-SALPINX WITH LUTEIN CYSTS OF THE OVARIES.

Dr. MACNAUGHTON-JONES also showed the adnexa removed from a patient for the results of gonococcus. The adnexa were quite covered over by peritoneum and were fixed by adhesions and effusion in the pelvic cavity, being attached to the rectum and intestine. The tubes were enormously dilated and hypertrophied; the smaller portions being perfect examples of desquamative and hypertrophic salpingitis. The patient made an excellent recovery.

MALIGNANT ADENOMA OF THE OVARIES.

In one case of a patient, æt 60, the tumour was the size of a cocoanut. There were disseminated particles on the bowel, and the omentum was considerably thickened. His first impression was that it was a papilloma, but Dr. Lockyer had reported on it as an adenoma, in which grafting and metastases might or might not occur. The cyst wall had become incorporated with the rectum. There was another small cyst behind the uterus. Satisfied of its malignant nature, he did not proceed further than the removal of the large cyst, but the patient had recovered well from the operation and had greatly improved. The stroma of the growth was composed of delicate fibrous tissue, sprouting into branching processes. The epithelium lining these and the spaces was of a benign columnar nature.

In the other case the patient had been tapped twice for ascitic accumulation; in the second tapping the cyst had been punctured, and when the abdomen was opened a large quantity of ascitic sanguineous fluid was evacuated. The cyst was very large and reached to the umbilicus. It was very soft and friable, having much the appearance of placental tissue to the naked eye. The bleeding in its removal was necessarily very severe, but was restrained by a large Miculitz tampon and drain. In this case both strychnine and free saline injections by the rectum sustained the patient, for her condition was almost hopeless before operation. She survived four days. Here there were no graftings; the second ovary was healthy, but both the naked eye appearances and the histological features as shown microscopically, and which he also demonstrated with the epidiascope, were very similar to those in the last instance. Dr. Cuthbert Lockyer had made a careful examination in this instance also, remarking that, though no distinct malignancy could be specified from the histological examination, still, in these growths the clinical symptoms and signs were such as were found in cases of a true malignant nature. The main histological features were adenomatous processes fused so as to form a loose network of spaces lined by columnar epithelium, in which there was necrotic debris.

The PRESIDENT said the specimens were most interesting. He asked whether Dr. Macnaughton-Jones found the gonococcus?

Dr. MACNAUGHTON-JONES, in reply, said that he did not find the gonococcus. He had at present a case under care in which the gonococcus had been found in the discharges. In that case the proof that the lady had gonorrhœa was that she knew all about it.

Dr. GEORGE BURFORD, in conjunction with Dr. JAMES JOHNSTONE read a paper on

TRANSFUSION: SUBCUTANEOUS AND INTRAVENOUS, IN GYNÆCOLOGICAL PRACTICE.

which will be found under the heading of "Original Communications," page 531.

The PRESIDENT said the paper was a most interesting one, both scientifically and from the medical point of view, and was worthy of discussion. In his experience, the only transfusion which had been necessary after operation was in the form of rectal injections. It was very strange how the degree of shock varied with different people. In some cases a slight operation would result in considerable shock, and in others of greater magnitude there would be scarcely any perceptible shock. In one case of hysterectomy which he did the patient was collapsed afterwards, although the operation was very simple. In that case he had to use rectal injections of saline fluids, and it was some time before the patient recovered. The authors had not said much about rectal injections, and he would be glad to know what they thought of their utility. In his experience they were very useful and simple.

Dr. MACNAUGHTON-JONES said that as no mention had been made of the name of the late Dr. Robert Macdonald, of Dublin, he should like to point out that he was one of the first, if not the first, to avail himself of gravity in transfusion, and Macdonald's transfusion apparatus was well-known and had been largely used. For more than ten years he had performed no serious abdominal operation without having sterilised artificial serum ready to hand for immediate use if required. The method he himself used was generally the sub-mammary, or the rectal, though the occasions on which either were required were rare. Both, however, had given him complete satisfaction, and in the gravest cases he had employed one or the other method with success. He had not used direct transfusion. He thought the plan of flushing out the abdominal cavity with normal saline most valuable, and he instanced cases in which all three methods had enabled operations to be completed. As to death on the table from operation, he was fortunate in never having had one. As to collapse from hæmorrhage, it was only in very exceptional cases indeed that in any modern operation death from this cause should occur. Our means of controlling hæmorrhage were so complete that practically now it need scarcely be considered.

CENTRAL MIDWIVES' BOARD.

MEETING HELD MAY 19TH.

DR. CHAMPNEYS in the Chair.

AFTER the minutes of the previous meeting had been read and confirmed, a letter was read from the Clerk of the Council transmitting an appeal for extension of time on behalf of a woman whose claim to be certified under Section 2 of the Act was made after March 31st. It was agreed to return answer saying the Board regretted its inability to comply. Sir William Sinclair remarked that he considered it rather a cruel thing on the part of the Board not to take into consideration the ignorance and illiteracy of the women who had delayed application till too late.

A letter from the hon. sec., Wandsworth Division Metropolitan Counties Branch, B.M.A., was then read, inquiring if midwives may legally engage themselves to Homes run for profit by members of the laity.

It was agreed that no answer need be sent.

Several applications for approval as teacher under Rule C, i (3) were read, and Dr. PARKER YOUNG rose

to protest against what he considered an unjust proceeding—i.e., to refuse an application because a man had not held a similar post. Surely, as in the case of one applicant, the fact of attending 2,000 cases was sufficient. Moreover, these lectures were often the only chance poor women living at a distance from a town had of training.

The CHAIRMAN reminded the speaker that it had been agreed to send a teacher to outlying districts.

Sir WILLIAM SINCLAIR then moved: "That the resolution of the Board of March 23rd, 1905, refusing the request of the Belfast Maternity Hospital for the recognition of its certificate as an approved qualification under Section 2 of the Midwives Act, be rescinded." It was, he considered, time to draw public attention to this hardship from which, through no fault of their own, they were suffering. The Board had made a serious mistake. For more than a century Belfast had trained respectable women to act as nurses in Ireland, and it would be a very serious thing for many such women to prepare for another examination. The application from Belfast had been received in plenty of time, but the Board did not do its work. The position of Belfast had been distinctly defined at other meetings. He would only add, there being no seconder for his motion, that the case was so clear, so right, that it was a matter of infinite amazement that the Board did not see it in that light. He intended seeking legal advice, and would see that the public were made acquainted with the facts.

After consideration of applications for certificates, the names of eighty-two women were passed under Section 2 of the Act, and ordered for entry on the roll.

The following shows the separate numbers of the various qualifications at present appearing on the roll: Royal College of Physicians of Ireland, 7; Obstetrical Society of London, 7,455; Rotunda Hospital, 426; Coombe Hospital, 124; Queen Charlotte's Hospital, 362; Liverpool Lying-in Hospital, 318; British Lying-in Hospital, 9; Glasgow Maternity Hospital, 322; St. Mary's Hospital, Manchester, 212; Manchester Maternity Hospital, 59; City of London Lying-in Hospital, 115; Royal Maternity Hospital, Edinburgh, 144; Salvation Army Maternity Hospital, 23; National Maternity Hospital, Dublin, 58; Limerick Lying-in Hospital, 15; Cork Lying-in Hospital, 28; Eden Hospital, Calcutta 9; Newcastle-on-Tyne Lying-in Hospital, 12; Dundee Maternity Hospital, 50; Aberdeen Maternity Hospital, 25; Women in *bona fide* practice, July, 1901, 12,516; total enrolled, 22,289.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS MAY 21st, 1905.

MERCURIAL INJECTIONS.

ALTHOUGH recommended nearly fifty years ago, mercurial injections for the treatment of syphilis have entered into current practice only within the last ten years. At the recent medical Congress held in Paris, two papers were read on this important subject by M. Lannois, of Lyons, and M. Balzer, of Paris, giving rise to an interesting discussion on the part of several members, of which the following are the principal points:—

There exist several kinds of mercurial injections. In some cases, a purely local action is aimed at, such as that realised by subconjunctival injections in infinite doses as practised by Prof. Bouchard. But it is especially as general treatment that mercurial injections are employed and the method preferred is that of intra-muscular injection which possesses numerous advantages. The absorption of the mercury is more certain, more rapid, and more intense than in other modes of treatment. Certain accidents may occur, however, from the subcutaneous method, such as the formation of nodosities or the production of intense irritation and pain; yet if the mercurial preparation be well chosen and the operation is done with care they may be avoided.

The injection should be pushed into the muscle and not outside it, preventing thus the formation of nodo-

sities if soluble salts are used or that of abscesses in the case of insoluble salts. Every antiseptic precaution should be taken both with the syringe and the seat of the operation, which is that of the gluteal region in its upper third. In order to avoid injecting into a blood vessel the needle is first inserted and if no blood oozes out the syringe is attached.

The hypodermic method comprises two different applications—daily injections of fractional doses and weekly injections of massive doses. For the former, the soluble salts are used, while the insoluble salts are chosen for the latter. The inconvenience of daily injections is easily perceived and can only be resorted to in a limited number of cases and under special circumstances. It is both costly and troublesome to the patient.

Intermittent injections of the insoluble salts are, on the other hand, easy to practice, and they possess a much more intensive action. Of these latter, the best are calomel, gray oil, proto-iodide of mercury, while the preparations of soluble salts are biniodide, salicylate and benzoate of mercury.

If calomel is painful, it has a rapid and powerful action. One grain suspended in vaseline oil is injected every eight days for about six weeks.

Gray oil contains 40 per cent. of mercury and must be well prepared. From one to two grains may be injected weekly for six to eight weeks, and renewed after an interval of two months.

Of the soluble salts, half a grain should not be exceeded daily, but it is better, in order to prove the tolerance of the patient, to begin with smaller doses, or one-fifth of a grain.

The indications for the use of insoluble salts, calomel, or gray oil, which produce marvellous results, are placed under six groups by Prof. Fournier:—

1. Phagedenism of the chancre.
2. Tertiary phagedenism more frequent than the former, but capable of making terrible ravages and destroying, for instance, the nose completely.
3. Dry tuberculous syphilis.
4. Gummæ of the larynx.
5. Psoriasis of the palms or of the soles of the feet.
6. Syphilis of the tongue.

LOCAL TREATMENT OF PHTHISIS.

Tracheal injections in the treatment of phthisis have been strongly recommended by Dr. Mendel, who has published a series of cases thus treated by him, and with encouraging results. His method does not require either frontal or laryngeal mirrors. A simple syringe (Beehag's) containing about a drachm of liquid, is all that is needed. The patient facing the light opens the mouth widely and breathes normally; the glottis is half open. The operator sitting in front of the patient draws forward the tongue and maintains it in that position. The syringe charged with oil of eucalyptus (1 to 5 in 100) is passed into the mouth, and the canula turned towards the glottis. The injector is pushed with a certain effort, and the patient, if the operation is well done, experiences nothing more than a sensation of heat penetrating his chest, and which is not disagreeable. The vapours of eucalyptol saturate the intra-pulmonary air and penetrate the whole of the lungs. The operation should be repeated three times at each sitting, and renewed daily.

The results obtained are: Considerable relief of the dyspnoea; decrease in the amount of expectoration, and relief of the cough; absorption of the softened tissues, that is to say, disappearance or decrease of the moist rales and return of the sonority in the apex of the lung.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, May 21st, 1905.

At the German Society for Surgery Hr. Jordan, of Heidelberg, read a paper on

RENAL OR PERIRENAL ABSCESSSES AFTER BOILS OR OTHER SMALL PERIPHERAL SUPPURATIONS.

He had made observation on twelve such cases.

which were all typical. In contrast with cases of multiple abscesses after infection we had here a hæmotogenous infection with a single localisation in the kidney, which was almost always unilateral. He had only had one case in which both kidneys were affected, the left kidney, however, being only in a state of inflammation without pus, and this subsided completely later on. There was no connection with the pelvis of the kidney, the urine being always normal. As regarded the situation of the abscesses, in one case the affection was intrarenal, in another perirenal. In six cases the abscess was on the anterior surface of the kidney. In most cases there was only a solitary abscess, in one there were several. No entrance gate to the poison could be proved. In five cases furuncle was the cause, in the others small superficial suppurations were the precedent condition such as panaritium, orchitis. The period of incubation was from one to four weeks. The localisation was uncertain and sometimes could only be fixed after the lapse of a fortnight or so. The reason why the disease was so often not recognised at first was that the general symptoms continued and, later, remittent fever occupied such a prominent position. In the first few weeks local symptoms were not notable, but later on there was tenderness on pressure under the twelfth rib and heightened resistance in the lumbar region. The diagnosis in the early stages was rendered easier by the knowledge of gate of entrance by pain on pressure under the ribs and the enlargement in the kidney region. In case of early diagnosis the prognosis was favourable.

As regarded treatment, it was well to wait until a perirenal abscess had formed. It was not advisable, however, to wait too long as from the continued high fever and great pain, secondary abscesses and toxic nephritis might endanger the life of the patient. It was better therefore to expose the kidney and open the abscess. After this the symptoms subsided rapidly, and in from four to six weeks the patient was quite well. Sometimes a post-operative fever was observed, but this did not interfere with recovery. If multiple abscess were found at the nephrotomy, nephrectomy was indicated and the speaker had done this in eight cases. He resumed as follows,—1. Intrarenal abscesses in consequence of a hæmatogenous infection were not rare. 2. Early diagnosis was formed after determining a point of entrance, pain on pressure underneath the twelfth rib of the affected side and enlargement of the kidney. 3. It was advisable to operate as early as possible.

Hr. James Israel remarked that the truth of what had been said by Hr. Jordan was borne out by recent experiences. It was difficult to form an early diagnosis, and he must state that his own opinion was that the three symptoms mentioned by him without a confirmation on the part of the urine were of only doubtful significance. In three cases he had found a mixture of red blood corpuscles in the urine. He also remarked that erosion of the nasal mucous membrane was the point of entrance in one of his cases.

Hr. Reidel, Jena, was at one with Israel's observations. He had seen such cases. On the whole they were rare, but it might be expected that copious material would soon be at hand considering the present-day conservative treatment of furuncles.

Hr. Schnitzler, Vienna, had seen such renal abscesses after even slight injuries to the skin, as from chafing from carrying a "Rucksack."

Hr. Heile followed with a note on
AUTOLYSIS AS A CURATIVE FACTOR IN SURGERY.
He said it was known that it was the leucocytes that were the ferment carriers, and that they gave up the curative ferment at the spot threatened. If it were possible to increase the number of leucocytes at such spots the body powers would be strengthened. He had performed experiments on animals with this object in view, in part by injection of certain substances and in part by the Röntgen rays. In this way the leucocytes were heaped up, and simultaneously destroyed so that their ferments could be set free. It was in this way that the X-rays acted in leukaemia. This also explained the action of Bier's artificial stasis in

inflammations. It influenced tissue metamorphosis in a favourable manner.

Hr. Heinecke spoke on

THE ACTION OF X-RAYS UPON THE SPINAL MARROW.
He said the X-rays acted very destructively on the cells of the spinal cord. Without exception cases of leukaemia were improved both objectively and subjectively. No cure had, however, yet been seen, as recurrences took place, the blood still containing pathological cells. The changes took place very rapidly, in the rabbit they were seen to take place in three or four hours. Numerous remnants of nuclei were seen. The highest point of the action was seen in ten hours to twelve hours. Soon after this the cell debris increased, the white marrow cells also, and on the fifth to the sixth day the marrow cells were quite destroyed. If the animal was left to itself the marrow became normal again in two and a half to three weeks. In animals that died within fourteen to sixteen days after X-ray illumination numerous mitoses, giant cells and fat cells were found. The result was not changed by short daily illumination. The cells grew again, and there was also the danger to the skin, that prevented too long exposure. The marrow cells destroyed quickly became restored, the basic cause of the disease was not touched, and the X-raying of leukaemic cases was not a curative procedure; it was at any rate, however, a useful palliative one.

At the Thirty-fourth Surgical Congress Hr. E. Küster, Marburg, related a case of

LOCAL APPLICATION OF TETANUS ANTITOXIN WITH RECOVERY.

According to Meyer's experiments infection with tetanus poison followed the axis cylinders of the nerves of the region infected. The imperilled centre could therefore be protected by the application of the antitoxins to the nerve tract. This method of treatment Kuster followed out in the case reported. A man, æt. 37, had twice contracted tetanus by inhaling dust laden with tetanus poison, but had recovered under the use of tetanus antitoxins. In the year 1902 a glass bulb filled with a virulent tetanus bacilli culture had burst in his hand and the fluid had flowed over the hand which was cut. The wound was immediately disinfected and an injection of antitoxin made. Six days later there was pain in the arm, and a difficulty in swallowing with rapidly increasing pain. A subcutaneous injection of antitoxin was again made, but without effect, and the patient was admitted into the surgical klinik. Kuster calling to mind Meyer's views, opened the axilla, freed the axillary nerve and injected it with antitoxin until the nerve trunk was distinctly swollen. The cervical nerves were also injected in a similar way above the clavicle. On the following morning the stiffness was distinctly less, and two hours later it had almost disappeared. Some days later pain appeared in the arm, but without stiffness, and this lasted for some months. The electrical excitability was normal. The case was therefore pronounced one of local tetanus with a six days' period of incubation, in which the prophylactic use of antitoxin was useless, but in which injection of the nerve trunk with tetanus antitoxin caused cessation of the muscular spasm within twelve hours. The speaker believed that the treatment of tetanus would be materially improved by this method. For the future he would recommend disinfection of the wound, or the sucking of it as recommended by Bier, and then the injection of the antitoxin into the nerve trunk itself. The only objection to this method appeared to be the risk of causing myositis, which in comparison with the risk of life, might be disregarded.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, May 21st, 1905.

SCIRRHUS VENTRICULI.

At the Physikalisch Gesellschaft für Medicin. Rindfleisch recorded the history of a case that recently came under his care. Was it cancer or non-malignant was the first question? The hard, surface extended

over a wide area of the gastric wall, forming a hard and resisting body when palpated externally. It was further complicated by a large number of small metastatic tumours present in the lungs, liver, and bones. The clinical phenomena were not in harmony with the diagnosis of carcinoma, although the metastasis in the lung and the severe leucocythæmia were prominent features in the case.

The histological examination proved the morbid changes in the stomach to be located to the deep coverings of the stomach, converting the thin layers into board-like material. The trabeculæ of the fibrous tissue was filled up with hard carcinomatous tissue, as well as parts of the glands which were confluent, forming a "closing plate" over the organ. The epithelium was quite absent over this area, giving the surface a smooth, hard appearance. According to the history of the patient the morbid changes had been a long time in developing, as he had suffered long from chronic catarrh of the organ, which probably caused the denudation of the mucous membrane and consequent infiltration of the fibrous tissue.

SYMPHYSTOMY.

Hofmeier next discussed the merits and demerits of symphysotomy, which he said had often been periodically advocated in Germany, but never generally accepted owing, he supposed, to the subsequent complications that frequently arose. When it comes to be a question of a live or dead child the operation is admissible, and with ordinary care can be accomplished without any risk or *post-partum* danger. Being almost a bloodless operation it can be carried out subcutaneously with a chain saw, with which he had performed about twenty times in his own practice. He usually entered the instrument about a thumb's breadth from the symphysis, and carried the chain around the bone, performing pubiotomy or hebotomy as it is sometimes designated. The most recent case was where perforation had been decided upon as delivery of a live child was impossible. The head of the child was large and unyielding in a pelvis below the normal measurement. The child seemed strong and healthy and the desire was to obtain it alive, while laparotomy was objected to. It therefore became a question of pubiotomy, which was performed and the symphysis stretched two centimetres during the process of delivery.

It may be noted, also, that the force of the soft tissues was greatly reduced. After extraction the patient was firmly bandaged, made a speedy recovery without any complication, and is to-day, four weeks after the operation, moving about the house in perfect health. Mother and child were both to be seen in a side room.

FOUNDATION MEMORIAL.

Geigel then commenced his oration to commemorate the fifty-fifth year of the Institution's existence. This oration is generally a retrospect of the progress of medicine, but for this "Festrede" he selected for his theme the latest addition to the armamentarium of medicine, viz., radio-therapy. After criticising the physical properties of the rays and the radio-active bodies with their emanations, he concluded with an admonition to all that the therapy was not without danger if recklessly applied, but yet may be of immense value when properly managed. He took advantage of this opportunity, he said, to relate a case which might be of interest to his hearers, and which he had treated in 1897, when the use of the rays in therapy were entirely empirical. Learning that the Röntgen rays affected sclerosis, and having a case of this kind in the optic nerve—with bilateral optic atrophy, the left amaurotic, unable to enumerate the fingers at $4\frac{1}{2}$ metres distant, while colour could not be distinguished and the general vision was very limited—the rays were applied, and in the course of a month's application the vision had improved from 10 per cent. to 50 per cent. in the normal, with ability to distinguish colours. By the end of 1900 the patient was able to take up his duties as forester. At regular intervals after long pauses the rays have been intermittently applied with apparent satisfactory results, but recently a rapid change has taken place for the

worse, leaving the poor fellow almost blind and in the last stage of amaurosis. Hirschfeld confirmed this opinion by quoting a case of his own where the rays had been applied to the internal ganglionic sheaths of the retina, which had finally produced optic atrophy. He would impress on his hearers the danger of this therapeutic agent in optic diseases, unless the rays applied were very feeble.

ALKALINE SALIVA.

Fleckseder gave a long record of experiments on the alkalinity and acidity of saliva in health and disease. Day and night, it is constantly alkaline in the healthy, as well as in nephritis and *ulcus ventriculi*. It is acid in fever with complications, perityphlitis, typhoid cholangitis, and severe cases of diabetes mellitus.

Continental Health Resorts.

[FROM OUR OWN SPECIAL CORRESPONDENT.]

AIX-LA-CHAPELLE (AACHEN).

THE hot-springs of Aix-la-Chapelle are rich in chloride of sodium. They contain also bicarbonates of soda, sulphate of soda, and sulphate of potash; so being somewhat aperient, they have the peculiarity of being perfectly free from sulphate of lime. In this they differ essentially from most other sulphurous waters, thus avoiding the disadvantages of indigestion and of detrimental skin action. The considerable amount of sulphur in the Aix-la-Chapelle waters is partly in the form of sulphuretted hydrogen gas and partly combined with sulphuret of sodium, thus giving full freedom for the healing powers of this sulphur in cases of metallic poisoning, skin diseases, and abdominal complaints. The most renowned spring is "The Kaiser." Its temperature is 55°C ., and it supplies the splendid baths in the Kaiserbad Hotel, the Neubad-Hotel Baths, and the "Queen of Hungary" establishment. Near it are the three other springs used in the Quirinus baths and hotel.

The waters of another notable spring, "La Rose" (48°C .), are received in a great subterranean reservoir, and supply the Rose Bath, the Comphansbad, and partially the modern and elegant Cornelius Baths, which also have a "Cornelius Spring" of their own, showing 45.4°C . In the Burtscheid suburb are many mineral springs and bath establishments, connected with a variety of hotels, known as the Rosenbad, Karlsbad, Neubad, Michaelsbad, Luisenbad, Schlossbad, Mühlenbad, &c. Among these Burtscheid springs is the one mentioned in our previous article as the hottest in Europe, having 77.5°C .

At Aix-la-Chapelle, for "the cure," are used the plain bath, the douche bath, and the vapour baths, all taken, usually, in combination with regulated drinking of the mineral waters. The most approved and scientific methods and apparatus are employed throughout, and applied under the supervision of the highest medical skill. There are English-speaking physicians resident all the year here, for the baths are open and frequented during the whole year, and a "winter-cure" is becoming popular.

A chief feature of treatment here is the peculiar and thoroughly efficient douche-massage of systematic rubbing and kneading administered by *masseurs* or *masseuses* holding Government certificates. This is begun in an empty bath, and continued until the bath is filled, thus not requiring the patient to leave the *douche-room* to enter the bath. The gentle irritation of the skin caused by the hot mineral waters and massage, and the perspiration, remain uninterrupted by this treatment. It is alike agreeable and efficacious, has a great alterative effect, and remedies exudations of both traumatic and gouty natures. Its influence on the tissues is proved by the decrease in the weight of the body, and by the increase of the excretion of uric acid and other ultimate products of assimilation (urea, chlorides, and phosphoric acid). The specific indications for Aix-la-Chapelle "cure" are:—

1. Rheumatism and gout.
2. Paralysis, lameness, atrophy of the muscles.

sequelæ of inflammations, bruises, accidents, contractions, stiffness of joints.

3. Mercurial and metallic poisonings.
4. Scrofula.
5. Skin diseases (eczema, acne, prurigo, psoriasis, ulcers).

6. Torpid liver, spleen, stomach, and bowels.

Excellent hotels and *pensions* abound both at Aachen and at Burtscheid, so that the preferences and purses of different classes of visitors can be readily suited. And many of these hotels have complete bath establishments under their own roofs, a material advantage for the avoidance of fatigue and of risks from exposure.

THE MEDICAL VISIT TO PARIS.

[FROM OUR OWN CORRESPONDENT.]

In our last we gave a brief account from the pen of our special correspondent of the now historical visit of a large body of representative medical men from Great Britain and Ireland to the French metropolis, as an affirmation of the *entente cordiale* now happily prevailing between the two nationalities. The notes from our correspondent embraced the leading features of what took place in Paris; he now sends us the following brief records of two of the excursions in connection therewith:—

VISIT TO EVIAN-LES-BAINS.

One of the most interesting and enjoyable excursions brought into being by the recent visit of medical representatives from Great Britain and Ireland was that to the celebrated health resort of Evian-les-Bains. At no point was the *entente cordiale* more strikingly manifest than during the reception by the Mayor and municipality, and subsequently at the banquet at L'Hotel Splendide, at which upwards of one hundred and fifty guests, belonging chiefly to the medical profession of both countries and their ladies sat down. The interest of the visit naturally centred in the thermal establishment, that world-famous French spring, whereat massage, douches, the drinking of the waters, etc., in gouty, hepatic, and albuminuric cases are carried out with that lavish regard to comfort, personal supervision and pleasurable surroundings our French *confreres* delight in. Few will forget the enthusiasm evinced at the banquet, and the felicitations exchanged by the speakers at the *rapprochement* between the two countries and its happy augury on the opening of the Evian season of 1905. In the afternoon the visitors were taken on a steamboat excursion on the upper lake, the charming scenery of which, with the added beauty of blossoming spring, will long dwell in the memory of all who had the good fortune to be present thereat. To the Mayor of Evian, his deputy, the director of la Socié^t Cachat and the resident members of the medical profession the most sincere and generous thanks are hereby accorded for the success which attended their whole-hearted hospitality.

VISIT TO AIX-LES-BAINS.

A select party of English, Irish, and Scotch medical men, accompanied by their wives, paid an informal visit to Aix-les-Bains, in connection with the many charming excursions organised in connection with the medical visit to Paris. They were received by Dr. Coze, the president of the Aix Medical Society, and were shown over the *Etablissement des Bains*, where several of them took advantage of the opportunity to try the famous *douche-massage*. All were impressed by the magnitude and completeness of the hydrotherapeutical installation. On the Thursday evening they were entertained at a dinner at the Hotel Lamartine, by M. Mottet, Mayor of Aix, and most of the local practitioners. He expressed the pleasure he had in welcoming them, and regretted that arrangements had not been made for a much larger party. He voiced the satisfaction that all Frenchmen felt at the *rapprochement* between the two countries, and congratulated Dr. Sillonville on having initiated the *entente*

cordiale, which had given such excellent results. The party left for Paris by the new *train de luxe* on the Friday morning.

Operating Theatres.

NORTH-WEST LONDON HOSPITAL.

COMPLETE REMOVAL OF HALF THE TONGUE.—Mr. MAYO COLLIER operated on a case of malignant disease of the tongue occurring in a man, æt. 62, whose family history was stated to have been excellent. The patient himself had always been a healthy man, but he acknowledged to have smoked a good deal in his younger days. Twelve months ago he had noticed an ulcer on the left side of the tongue; this, however, had healed up. Three or four months before the present time a painless ulcer had formed on the right side of the tongue opposite a bad tooth. On admission the man presented an ulcer with hard everted edges involving the posterior portion of the right side of the tongue and the anterior pillar of the fauces. There were enlarged glands in the right submaxillary triangle. Mr. Collier said that whenever practicable the complete removal of one half of the tongue was altogether a more convenient procedure than removal of the anterior half or two-thirds of the whole organ. It was true, he remarked, that this procedure could only be carried out when the disease was well away from the mid line, as in the case about to be operated upon. In the present instance, the epitheliomatous ulcer was situated at the side of the base near the junction of the anterior pillar of the fauces, not an uncommon situation in this disease. The early recognition of the nature of the disease was, he considered, all-important in contemplating the one-half removal or otherwise or not of the organ. He pointed out that it had been objected by authorities on operative surgery that one-half removal of the tongue left the patient in a less satisfactory condition than the removal of the greater part of this organ, but a considerable number of cases on record would tend to disprove this idea. Mr. Collier said that in one case he had recently exhibited before the British Laryngological Association, where he had removed the entire lateral half of the tongue up to the epiglottis, the patient, three weeks after operation, was able to taste and chew his food, and to talk with almost as much ease as when the complete organ was present. He also pointed out that so far as the operation was concerned, it was a safer and much less severe procedure than when the anterior half or two-thirds of the tongue was removed. So far as the immunity from a return was concerned, he said that by ligaturing the lingual artery at the same time as removing one-half of the tongue, the first barrier of lymphatic glands could be got at and removed; the lymphatic glands in immediate association with each half of the tongue were arranged, he stated, in two groups; the lymphatics of the posterior two-thirds accompany the lingual vein and pass through the lingual lymphatic glands on the hyo-glossus muscles, and terminate in the superior deep cervical glands that lie between the external and internal carotid vessels; the lymphatics in the floor of the mouth and anterior part of the tongue pierce the mylo-hyoid muscle and join the submaxillary lymphatic glands. He said that one of the objections to ligaturing the lingual and removing the glands in the submaxillary triangle, previous to removing the whole or part of the tongue, is stated to be the time this procedure usually occupies; but the last operation in which he had ligatured the lingual and removed the whole of the glands in the

submaxillary triangle occupied less than ten minutes, and he hoped to be equally expeditious in the case about to be operated on. If it were felt desirable to remove the upper deep cervical glands, this could be done by prolonging the incision backwards, and ligaturing and dividing the facial vessels, or this part of the operation could be postponed till the wounds had healed. Mr. Collier, having passed two stout silk ligatures through each half of the tongue, after ligaturing the lingual artery and removing the glands of the submaxillary triangle with a straight pair of scissors, divided the tongue from before backwards close to the median raphe; the mucous membrane of the floor of the mouth was divided close to the jaw, and this and the sublingual gland included in the section. The tonsil and anterior pillar of the fauces were separated from their connections and taken away with the tongue up to as far as the epiglottis. During the whole procedure there was no hæmorrhage except when the tonsil and the anterior pillar of the fauces were being dealt with. The procedure occupied but a few minutes and the patient returned to bed without the usual anxiety attendant on these cases. Mr. Collier said that finally he would strongly recommend the operation he had just performed in all suitable cases.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, MAY 24, 1905.

TROPICAL MEDICINE.

THE successful banquet of the London School of Tropical Medicine, held on May 10th, brought forward the needs of that excellent institution in a way that we hope will secure a ready and generous response from those quarters where a balance of income over expenditure enables the possessors to indulge in the luxury of giving without privation. It is difficult to conceive of an object for beneficence more worthy of support than the School of Tropical Medicine. Imperialists and "Little Englanders," poles apart though they may be with regard to the expansion of the Empire, cannot fail to agree that a grave responsibility is imposed by conquest on the conquerors. In fact, the only legitimate plea for the conquest of savage tribes and half-civilised people is that

their state of subjugation shall be one of greater benefit than if they were left to their own devices or relegated to the tender mercies of a "friendly" Power. Now it is a legitimate claim that, serious as have been individual lapses, the administration of conquered countries by the British has been far ahead in justice and humanity of similar government by other Powers. Indeed, British administration has set the model on which other European countries have fashioned their rule in savage lands, and in so far as it has approximated to it such administration has been successful. Now medical men hold that there is nothing that confers greater temporal benefits on a people or conduces more to peaceful development and content than good health. So that the doctor, as State adviser, should follow closely in the wake of the soldier, if the last state of the conquered is not to be worse than the first. Unfortunately in the past this great secret has not been so apparent, as it ought to have been, chiefly because the science of medicine as regards the diseases of hot climates had not developed to the point at which it could be of indubitable utility in the prevention of disease. This reproach, a very just reproach, is now happily well on the way to being removed. Tropical medicine has received an impetus in the last twenty years that has enabled it to reach a point of evolution that almost justifies the use of the term "revolution." The birth of parasitology, at least as regards bacteriology and protozoology, has given new concepts of disease to physicians who used to dispute over types of fever and miasmatic influences, without realising in the least the ultimate etiological factors that lay behind them. The names of Laveran, Manson, Ross, Kitasato, and a band of others down to the lamented Dutton, will remain honourably and indissolubly connected with this first stage of this materialisation of disease-producing factors. Great, however, as have been their triumphs, they have but prepared the ground, and in order that their labours may come to fruition it is necessary that a host of enthusiastic and self-sacrificing investigators shall water and till and garner where they have worked. But profitable to the Empire as such labours may be, they are far from profitable to the investigators themselves, and if men in the right numbers and of the right sort are to be forthcoming they must be assured of at least a competency during their working years and the possession of the proper apparatus with which to carry on their pursuits. At the present moment the School of Tropical Medicine is seeking to raise £100,000, with which to equip the school and pay their lecturers. Seeing what lies before them this sum is ridiculously modest, and it is one which ought to be forthcoming without the slightest difficulty. The Government have been pleased to smile benignly on their efforts, but it is hardly likely that, whichever side is in power, they would ever be prepared to do anything adequate in the way of endowment. At present, a Departmental Committee is sitting to co-ordinate the work of

the Royal College of Science with that of the other institutions concerned in scientific and technological work in London, and Lord Londonderry has promised that a certain sum shall be forthcoming from the Treasury to forward the working of these institutions. We can hardly expect that the London School of Tropical Medicine will share to any appreciable extent, if at all, in this tardy grant, and therefore it must look to the public to supply the necessary funds. This is no case for what Huxley, in speaking of technical education, called "twenty years of cheerful, hopeful blundering"; it is a case of a definite project with definite aims and definite means of attaining those ends. All that is lacking is money. The banquet produced some £10,000 of the £100,000 required, and it will be a standing reproach if the rest is not subscribed many times over. The investment is one that will pay a hundredfold, not in half-yearly dividends, but in health, happiness, and prosperity to the Colonies for which we are directly responsible, and, indeed, to all those who live in the Tropics. With a reduction of the disease and death-risk of employment in hot climates, the best type of man will be available for service where till lately the desperate and broken-down only ventured, and the vindication of British justice in future will lie not in the parade of cordite and pom-poms but in improved methods and standards of living.

ANTIPYRETIC THERAPEUTICS.

THE science and the art of medicine do not necessarily cohabit in the mind of the practitioner; they dwell apart and are not allowed to hamper each other's movements. No better proof thereof is needed than the universal employment of antipyretic drugs in spite of the laboratory conception that a high temperature in acute specific diseases may be the reaction of the organism in presence of pathogenic bacilli. Experiments *in vitro* show that many of these organisms are unable to multiply at pyretic temperatures, whence it may be inferred that the best, indeed the only, way to check their activity in the blood and tissues is to maintain and, if necessary, even to determine, a high temperature for the purpose of "smoking them out." Yet no sooner does Nature set this sterilising process in motion than the practitioner does his best to reduce the temperature to one at which pathogenic microbes flourish exceedingly. Were the premisses of this argument absolutely sound it would be difficult to justify, or even to excuse, this method of treatment, but, fortunately for our sense of logic, there is a sufficient margin of error to obviate the conclusion that we are thwarting the natural curative process. First of all, it is our painful experience that a high temperature is not *per se* curative. However they comport themselves in the laboratory towards temperatures of 40° C. or thereabouts, many pathogenic microbes appear to live on very comfortably in the human body under febrile con-

ditions and ultimately carry their labours to their logical conclusion, *viz.*, the death of their host. We know, too, that high temperatures are inimical to the functional integrity of the various tissues and organs, and it is a reasonable assumption that the defensive forces of the human organism are thereby impaired. The nervous system is profoundly disturbed and its control diminished, the digestive functions fall into abeyance, and, most important of all, the kidneys become unable to discharge their eliminatory function so that the lethal toxins accumulate within. After all, the prognosis turns less upon the quantity of toxins elaborated by the invading bacilli than upon the ability of the organism to get rid of them. Sometimes, as in typhoid fever and diphtheria, it is possible to control, in some measure, the production of toxins, but in others, as in pneumonia, the foci are inaccessible to any means at our command. Until comparatively recent times the treatment of acute diseases was limited to favouring the elimination of the toxins *via* the natural emunctories, and even now, though by the use of sera and antitoxins, we can in some instances inhibit the vital activity of the bacillus or neutralise their effects, the getting rid of the products of microbial activity is still the most important part of treatment. One way in which the action of antipyretic drugs may be construed to be favourable is that a sudden reduction of temperature is invariably accompanied by profuse perspiration which carries off much that the overburdened kidneys have been unable to excrete. The presence of albumen in the urine in the course of an acute disease is evidence that the kidneys are unequal to the strain thrown upon them, and indicates the necessity for promoting elimination by the skin and intestines, the only alternative paths for the accumulating toxins. Hence in typhoid fever, for instance, it is unwise to check even excessive diarrhoea by astringents, since their only effect is to "bottle up" the material; moreover, the desired effect can be brought about much more certainly and efficaciously by the administration of intestinal antiseptics. Venesection is only of value in that it enables us to rid the organism of some of the accumulated toxins and it is at best an extravagant, wasteful mode of doing it; indeed, it is like throwing a carpet out of the window to get rid of the crumbs. In view of the comfort that follows the reduction of febrile temperatures the employment of antipyretics is not likely to be abandoned, the more so since, in practice, that reduction is at least as favourable to the cell-defenders as to the microbial invaders of the organism.

GUILD OF HEALTH.

OUR attention has been drawn to a movement which was started some little time ago under the guidance of certain Church of England clergymen, and which has already resulted in the formation of a body called the "Guild of Health." We are

inclined to think from what we have seen of this Guild and its propaganda that it is not likely to become popular among that class of the community which is ever athirst for sensation and wonder-working. But as the promoters of the Guild express great admiration for the medical profession and a sincere desire to aid them in their work with the sick, we may perhaps be permitted to point out to them in a friendly way the dangers into which they and their followers are likely to fall. The objects of the Guild are defined by themselves to be: (1) the cultivation, through spiritual means, of both personal and corporate health; (2) the restoration to the Church of the scriptural practice of divine healing; and (3) the study of the influence of spiritual upon physical well-being. It is somewhat naively admitted by the promoters of the movement that they have been stirred into activity by the success of the Christian Scientists, whose hold on America is already so great and whose tenets are accepted by a small but increasing body of persons in this country. Mrs. Eddy, as a leader, is not approved, and her book is characterised as "a curious mixture of bad philosophy and worse English"—a definition to which we raise no demur. The interesting point is that a person gifted with sufficient critical powers to have penetrated the husk of speciousness that encloses the withered platitudes of "mother" Eddy, should not have been able to carry his discrimination to the logical conclusion, and have condemned as an outrageous violation of common-sense and good manners the extortionate system that is reared in this foundation of "bad philosophy." The actual deduction drawn is, that on the principle of there being no smoke without a fire so there must be something in Christian Science after all, and that something is presumed to be a latter-day manifestation of the gift of healing committed to the Church. The author of these observations cannot be accused of a narrow intolerance, for he classes together all sorts of faith-healers, from the tribe at Lourdes to the heathen priests who effect their cures before idols in India, China, and Africa, and he says that all these have both saints and charlatans among them. We confess it strikes us as odd that fetish priests could be regarded by Christian divines as "saints," and it makes us wonder how St. Francis of Assisi would feel if he found himself enshrined in the same canon as a Hottentot medicine-man. But the question that is urged is, whether, since so many religions have their cures and their spiritual healing, the Church of England ought not to have hers. In fact, it is strongly suggested that the Church once had her wonderful cures, but through negligence has lost her power to work them. The object of the Guild of Health is to try and find out how this power can be regained. The Church must set her house in order, repent her want of faith, and restore in her midst her way of spiritual healing. She must not discourage the Eddyites, but take a lesson from them,

and try to cultivate a band of men who practise spiritual healing, and rejoice "in the power of silence." If only faith-curiers who rejoiced in the power of silence were to be forthcoming, we should feel almost inclined to welcome them ourselves; the quality of unbounded loquacity we had deemed to be part of the stock-in-trade of the healing fraternity. A great deal is made by the Guild of the fact that in the early prayer-books there were distinct offices for use in the healing of the sick, and we actually find a service used when people came to be cured of the "king's evil" cited in evidence! Is it really proposed that the Church should become party to the treatment of tuberculous glands by the laying on of the Sovereign's hands? It would almost seem so. It is hoped that by the revival of the anointing and other ceremonies the discovery will be made as to which priests possess the gift of healing, and that these may be able to use their powers on the sick. Our mind naturally turns to that sturdy little sect, the Peculiar People, who have been trying to make this discovery for a long time, but who have not been very successful if one judges by the evidence of the coroners' courts. Now, as we have said, a movement on the lines defined by the Guild of Health is sure to attract many adherents, and we would strongly advise the founders of that Guild if they wish to act fairly to take counsel first of all with the medical profession, for whom they express a genuine regard. No one in his senses denies the power of the mind over the body, in health and disease, and it is precisely those cases in which the mind is diseased that suggestion, or spiritual healing, or hypnotism, or whatever name may be used for the process, affects its apparent triumphs. But that these "cures" are cures in any permanent or satisfactory sense is well known not to be the fact by anyone who has taken the trouble of finding out the subsequent history of the cases. Neurotic invalids only improve substantially by the judicious and careful handling of a wise and competent physician, and are apt to go from bad to worse when treated by ignorant people who work by exciting their already morbid imaginations. If the Guild of Health will confine itself to encouraging weak and nervous patients to rely on their doctor's advice, and to helping them to follow it out, it may do good work; if it falls to the curing business itself, the Guild is likely to find itself in a false and invidious position.

Notes on Current Topics.

Admiral Rodiestventsky's Illness.

THE reported recall of the Russian Admiral Rodjestventsky adds one more dramatic touch to the great war-game now being played in the Eastern seas. For many weeks mankind has been waiting with tense interest for news of the titanic sea-fight which may readjust the relations of the whole world for centuries to come. At this supreme moment the health of the Russian Admiral

is said to be so bad that he has asked to be recalled. The Paris newspapers are mainly, but not altogether, responsible for this report. At any rate, we know that Rodjestventsky has for some time past suffered from a form of dysentery. It is now stated that he has a return of an old nervous complaint, involving paralysis of the muscles, and further complicated by inflammation of the kidneys. Assuming these details to be correct, the complaint is obviously a recurrent attack of peripheral paralysis induced by some deleterious agent in the circulation that has also damaged the kidneys. Peripheral, or, as it is popularly known, "creeping" paralysis, may, of course, be due to a variety of poisons. It may result from malaria and other tropical diseases. It may be caused by arsenic, lead and other drugs, but the commonest source of the mischief is alcohol. In the United Kingdom this form of palsy became painfully familiar a few years since by an epidemic due to arsenical beer in Manchester and other northern towns. It is inexpressibly sad to see the leader of a great armada struck down in this way on the eve of battle.

"Too Much Operating."

THE attention of the public has been aroused by a fresh newspaper sensation under the cry of "Too Much Operation." As the public supplies the patients that come under the tender mercies of the surgeon, they clearly have a right to a voice in the matter. The matter is not one that can be dismissed in one or two brief sentences. A few considerations, however, may with advantage be laid before the man-in-the-street. First and foremost there can be no question whatever that modern surgery saves an enormous number of lives that formerly would have been lost. Many serious internal conditions are now cured by the prompt use of the knife, where, in old days, there would have been nothing to do medically beyond rendering the passage into the hereafter as painless and easy as might be. In many abdominal and other internal conditions there is probably not half operation enough. Where the thing is overdone is in the hands of some specialists who, in many cases, charge exorbitant fees for operations, the necessity for which is not obvious. But the day of the non-operative surgeon is done. Dr. Ernst Schweininger, who has raised the cry of alarm against excessive operation, is one of the old conservative school whose views belong to a prebacterial and preaseptic school of surgery. The average layman will act wisely, when it comes to a question of this kind, to place himself wholly in the hands of a medical practitioner of conscience and repute, and to abide by his decision.

The Midwives' Board.

IN the interest of public policy we call attention to the report of the recent meeting of the Midwives' Board, held in London on the 19th inst. Sir William Sinclair had given notice of a resolution to rescind the refusal of the Board to recognise

the Belfast Maternity Hospital. If there could be any single matter brought before the attention of the Board deserving more careful consideration than another it is this decision which deprives a hospital of old standing and good repute of its fair and equable rights as regards the training of midwives. As a matter of fact, Sir William's motion was talked out. The time of the Board was wasted over a number of trifles, while a matter of such prime importance as that of the survival of a time-honoured and flourishing hospital training school was relegated to the last ten minutes of the meeting. Nothing could better demonstrate the inherent badness of the Board's methods. A great national trust has been placed in their hands to organise and control, but their methods in dealing with Irish affairs, at any rate, have been suggestive of the parish pump and the wire-puller, rather than that of the broad, generous justice of the enlightened administrator of public affairs. It is to be hoped that the general Medical Council, the British Medical Association, and Parliament will keep an eye on the working of the Midwives' Board.

Reported Discovery of the Micro-Organism of Syphilis.

NEWS comes from Paris of the discovery of the specific micro-organism of syphilis. The original discovery was made by Professors Schaudin and Haussman, of Berlin, in the shape of a spirillum that had satisfied the conditions necessary for identification as the causative organism of the malady in question. In communicating this momentous observation to the Paris Academy of Medicine recently, the Dean, M. Metchnikoff, said that he had established the presence of the specific microbe in monkeys inoculated with the virus taken from the human subject. Coming from so cautious and distinguished a scientific observer, this confirmation carries with it the utmost weight and authority. Should the discovery be ultimately confirmed, as appears to be more than likely, before long a new era will possibly be established in the treatment of one of the great scourges of mankind. Sooner or later the essential cause of syphilis was, humanly speaking, certain to be disclosed by the researches of modern science. For some years past the microbial origin of the disease has been accepted generally in the world of scientific medicine. It is curious that such well-marked bacterial diseases as syphilis, scarlet fever, typhus, measles and small-pox have been enabled to keep their secrets so long from the enthusiastic and well-equipped onslaught of the soldiers of the modern bacteriological army.

"Special Pathologists" and Inquests.

THE indignity bestowed upon the medical men of the Westminster District by their Coroner, who practically excludes them from *post-mortem* examinations and evidence at inquests, is being recognised in ever-widening circles throughout the country. The *Sussex Daily News*, for instance,

in its issue of May 15th, contains a crisp leaderette that sums up the case in a nutshell. Among other wise remarks we find the statement that "in the vast majority of cases the evidence of the ordinary medical man is sufficient to establish the cause of death, and the services of a pathologist are not required." It may be said, so far as that goes, that in many cases the evidence of the medical attendant is absolutely essential to a proper verdict, whereas the unsupported testimony of an "expert" (save the mark!) pathologist may be futile, and even misleading, as it is certainly, in the long run, far more costly to the ratepayer. The journal we have quoted winds up with the remark that the matter is, "of course, one for the medical profession as a whole to deal with; but the public will undoubtedly sympathise with the general practitioner." The medical profession, we are glad to say, are dealing with the matter pretty energetically. Westminster medical men are in open revolt; the British Medical Association is fighting tooth and nail; the medical journals are up in arms. On the other side, Mr. Coroner Troutbeck sticks to his guns. There can be but one issue to a conflict fought under such disproportionate odds. The ultimate issue, however, depends with the local governing bodies elected by the ratepayers.

The Rontgen Rays and Internal Cancer.

THE efficacy of X-rays in the treatment of certain superficial cancers can hardly any longer be denied, though it is still a question in each individual case whether such a method of treatment is the most suitable. It is disputed, however, whether the rays can be made use of with any chance of success in the case of cancers that are deep-seated. Contradictory reports reach us from the States, while up to the present there is but little recorded experience in this country on the subject. Dr. Cleveland, of Norwich, has recently drawn attention, however, to the results of X-ray treatment of a case of supposed cancer of the fundus of the uterus, in which removal had been regarded as impracticable. It appears that carcinoma of the body of the uterus having been diagnosed clinically, a laparotomy was performed in November, 1903, with the intention of removing the organ. On opening the abdomen, an irregular tumour was found springing from the fundus, growing into the broad ligament, and apparently implicating the pelvic wall and the sigmoid flexure. Although none of the growth was removed for examination, there was no doubt in the minds of the surgeon or those present as to the correctness of the diagnosis, and, complete excision being regarded as impossible, the operation wound was closed. A few weeks later the patient came under X-ray treatment, and after six months' continuance all signs of a tumour and all symptoms of disease had vanished, and the patient has been since quite well. Of course, it is impossible to affirm positively that the case was truly one of cancer;

nevertheless, such a diagnosis is not lightly to be brushed aside merely because recovery has taken place.

New Use for the Appendix.

THERE is an old saying that condemned persons live long, and it seems that that much-anatomised structure, the appendix vermiformis is about to take a fresh lease of life. It has been told that it is obsolete, useless and dangerous, and yet, with a hardihood worthy of a better cause, it persists in cropping up in infants as they appear in the world, and in causing endless trouble to lots of them in later life. Several medical apologists have ventured to take the field in its behalf, but they have been given but scant attention by the abusers of the appendix, and generally they have been branded as fools and faddists. Sir William McEwen made a brave attempt to stave off the unpopularity of this little organ, but his voice, for the most part, fell on deaf ears. Now Mr. Jonathan Hutchinson, junr., we notice, has come forward, and states that he has found a purpose which the appendix may be made to serve. In the treatment of membranous colitis by irrigation it has lately been the habit of surgeons to make an opening for the time being into the cæcum, and through this aperture to wash out the colon from above downwards to the rectum. This procedure entails on the patient all the discomfort of an artificial anus, and Mr. Hutchinson simply now brings the appendix out through the wound, inserts a catheter in it, and uses this for daily irrigation. At the end of the treatment the appendix can be either amputated or replaced in the abdomen. Surely the uses of adversity are sweet!

Slump in Medicine Bottles.

SIR WILLIAM JENNER used to say that typhoid fever was worth £100 a year to any man in practice, and it speaks well for the altruism of the medical profession that they should have been striving to annihilate such a profitable complaint, for, what with the diminished incidence of the disease through pure water and good sanitary arrangements, and the provision of isolation hospitals for the bulk of the sufferers, doctors' fees from typhoid patients have been considerably reduced. But we have heard no complaints on this score from the profession. It appears to be otherwise with the medicine bottle sellers, however, if the evidence of a defendant in the Lambeth County Court is to be believed. This individual was sued for a debt, and he pleaded in extenuation that "things were so bad with doctors" now that his takings from the sale of medicine bottles had been considerably reduced. The doctors had told him, he said, that sanitary arrangements have been made so good that business now is not what it used to be. Defendants in County Court actions have many ingenious excuses for not being able to pay, but, as Judge Emden remarked, this particular piece of news would be very welcome to

the county and borough councils of the metropolis. Unfortunately, however, he was sufficiently hard-hearted to make an order for payment at ten shillings a month until the doctors' business gets better.

Spontaneous Combustion.

THE easiest thing in the world is to prick a bubble, and the hardest thing is to persuade people that the bubble has burst after the collapse has taken place. Bubbles are so attractive, pretty, and illusive that it is regarded as the act of a Philistine to deprive people of the romances that can be woven round them. A particularly cherished bubble is that of the spontaneous combustion of the human body; it has existed in people's minds for many ages, and they naturally do not like to see an old favourite deposed. Indeed, in some current works on medical jurisprudence spontaneous combustion is treated of seriously, and articles on the subject appear from time to time in medical journals. A vigorous and learned paper by Dr. Knott appeared last month in *American Medicine*, which should finally lay this unsubstantial ghost. He traces the history of the idea from its origin in certain facts that would give plausible colour to the hypothesis, such as inflammability of the intestinal gases, the low combustion point of alcohol, and the reported proneness of dried grasses to take fire when heaped up. Thence the notion took shape through the alchemical theories of *ignes lumbentes*, and finally came to be attested by the deaths of drunkards and others under unusual circumstances. The records of the Royal Society and other learned bodies contain accounts of persons whose deaths were supposed to have been caused by spontaneous combustion and through the seventeenth and eighteenth centuries the belief was generally accepted by practically all scientists. Dupuytren, it is interesting to notice, was a determined, though almost solitary foe to the current opinion of his time. The danger that attends the belief at the present day is that it may be used, as in the past, to explain the deaths of drunkards who are found dead and partly burned, and that the idea is not absolutely eradicated is witnessed by the quotation from a twentieth century Anglo-Saxon authority, who seriously believes in spontaneous combustion taking place *post-mortem*!

Hygienic Improvements in Factories.

A PAPER of much interest was read at the Royal Statistical Society on May 16th by Mr. Leonard Ward, H.M. Inspector of Factories, on "The Effect as shown by Statistics of British Statutory Regulations, directed to the Improvement of the Hygienic Conditions of Industrial Occupations." A brief historical *resume* was given of the conditions of labour in mines and factories before the State intervened on behalf of the worker's health and life, and also of the progress of the early years of industrial legislation. The effect of the hygienic

enactments in checking these abuses was then considered from three standpoints, namely, that of the mortality rates, that of sickness experience, and that of the physique of the operatives in selected occupations. In cotton manufactories, of which, from their old establishment and local conditions, no trustworthy information could be obtained for many years, Mr. Ward showed that the fall in the death-rates from phthisis and respiratory diseases had been most marked, especially since the passage of the Cotton Cloths Factories Act of 1889. The physique of the operatives was studied by comparing factory children in 1833 with those in 1873, and non-factory children in the same periods. Here, though it was shown that in 1873 factory children were ahead of those in 1833 in build and development, the improvement was not so noticeable as between the non-factory children of the same period—a fact the lesson from which would be that much yet remains to be done to make young factory operatives the equals of their fellows. But the benefit that accrued to the textile workers was not shared by pottery workers till 1890, when the special rules with regard to lead-poisoning were introduced; these rules have since been of immense benefit. Perhaps the most convincing figures were those given of coal miners, who, from being one of the most unhealthy classes in the community, have, under fifty years of statutory regulations, become as healthy as agricultural labourers. Mr. Ward estimated that 50,000 lives had been saved from death by explosion alone since the ventilation clauses of the 1855 Act came into force. Its factory legislation is perhaps one of the greatest glories in the British constitution.

Exeunt Infants.

WE notice as much with surprise as with satisfaction that the Board of Education is proposing to set its face against infant classes in schools. We have pointed out in these columns, in common with other organs of medical opinion, the sheer folly of trying to teach children whose ages range between three and five years old anything that they could take in without detriment to the little growing brains, and the cruelty of attempting to teach them anything that would be of detriment. Moreover, we have shown that the infant classes of the elementary schools are hot-beds and breeding places of disease, for it is notorious that nearly all the epidemics of measles and whooping-cough that periodically disorganise the school-working are traceable to these poor little brats who are huddled together at a tender age to be "instructed." The Board of Education has come to realise this, and they propose to withdraw the Imperial grants from infant classes, which will of course mean that no local educational authorities would think of persisting in the conduct of such classes entirely at the cost of the rate-payer. By so doing the Board would have at its disposal a sum of £900,000 a year, and when so many improvements in secondary and technical education

are held in abeyance through want of money, this sum will be most acceptable. We regret to see that some well-known educationalists are raising their voices against the policy of the Board on the ground that the infants will have nowhere to go in the daytime if the classes are closed. Surely this is the height of absurdity from the educational standpoint; that is, if education is a serious business and not a stalking-horse for the relief of people from their parental duties. The Board of Education will have the whole-hearted support of the medical officers of schools.

Early Infection with Tubercle.

OPINION, on the whole, has not so far inclined towards agreement with Professor von Behring's views on the period and mode of infection with tuberculosis. Nevertheless, from time to time, evidence comes from undoubtedly accurate observers, which is in support of his doctrine. Of this nature is the report of Dr. F. Harbitz (*Journal of Infectious Diseases*, March, 1905) regarding his own personal experience, and the results of his study of the literature of the subject in Scandinavia. Out of thirty bodies of children dying under the age of fifteen examined in Leipsig, Harbitz found tuberculous lesions in nine. In Christiania, in the course of 275 autopsies, tuberculosis was revealed in 117 cases. Of these 117, 72 died of the disease, while in the others the disease was latent. Again, of 123 bodies under one year of age, 25 were tuberculous. Arguing from his experience, Harbitz holds that tubercle bacilli may remain latent in a lymph-node for twenty or thirty years, if not longer, and he believes that in many cases pulmonary tuberculosis in adult life is secondary to an infection elsewhere in childhood.

Morphology of the Tubercle Bacillus

It has long been known that the term "bacillus" as applied to the organism of tuberculosis is somewhat inaccurate, since it is not unusual for it to occur in forms and arrangements which a bacillus never adopts. Many of these occasional forms resemble so closely those adopted by organisms of the actinomycetes that many bacteriologists have thought fit to class it under this head, and the term "*mycobacterium tuberculosis*" given by Lehmann and Neumann is probably the most accurate yet applied. An interesting account of the various forms adopted by the organism has recently been published (*Medical News*, Feb. 25th, 1905) by Dr. Charles Craig, of the United States Army, who, from his experience in examining the sputum of soldiers invalided from the Philippines, is of opinion that variations appear more commonly in tubercle when occurring in the Tropics than in the disease as we are accustomed to it in temperate regions. In addition to modifications in length, in breadth, and in staining reaction, which Dr. Craig regards as very common, he mentions certain definite variations from the common types which may be of morphological

importance. The most frequent of these, and one with which all observers are familiar, is the beaded or streptococcic form, where in the stained specimen coloured and uncoloured areas alternate with great regularity. Less common is a clubbed form, which closely resembles certain forms of actinomycetes; this resemblance is made all the clearer by the fact that the clubs are usually collected in masses. In the majority of his specimens of sputum, Dr. Craig found definite budding forms, and these he regards as an early stage of the branching organisms which he also found very common. In many cases branching masses so dense were found as to suggest ordinary actinomycosis. If it were a mere question of nomenclature, the term by which we are to designate the organism of tubercle would be a matter of little importance, but since the name applied to it should suggest the class in nature to which it is found to belong, the problem becomes one of great interest to science. So far Dr. Craig's observations bear out the conclusions of Lehmann and Neumann in placing the organism of tubercle among the actinomycetes.

Anticipations of Inventions.

WE commented a few weeks ago on the many inventions closely resembling Señor Garcia's laryngoscope which shortly preceded the actual introduction of that instrument. It is interesting to note that in the history of scientific discovery very many inventions of the greatest importance have been anticipated or foreshadowed in similar manner. It has usually happened that the successful inventor has succeeded by bearing in mind some small point overlooked by his predecessors, or by hitting, by a happy accident, on some slight improvement in mechanism or mode of work which renders what may have been a toy an instrument of scientific value. In the case of the discovery of the use of ether as an anæsthetic, while all the honour may probably rightly rest with Morton, the Boston dentist, yet there were many others who previously knew of the anæsthetic properties of this drug. As early as 1795 Dr. Richard Pearson published a work on the sedative value of inhalations of sulphuric ether, and this property is referred to by many writers during the forty years following. In 1828, Hickman, a London surgeon, reported to the French Academy of Medicine a method of suspending sensibility by the introduction of certain gases to the lungs so that the most dangerous operations could be performed without producing pain, but he does not record the nature of the gases employed. In 1842, Long gave ether successfully for the removal of a small tumour, but after some failures he gave up its use and thought no more of it till Morton's demonstration four years later. Curiously enough, in the case of nitrous oxide, although Sir Humphry Davy had suggested, in 1800, the possible surgical value of that gas, it was not till 1844 that there is definite record of its use as an

anæsthetic by Wells, and it was not till the late sixties that it was adopted by the dental profession in London.

The Direct Representative for Ireland on the General Medical Council.

IN addition to the two candidates already in the field for the post of direct representative, Sir William Thomson and Dr. L. Kidd, a third candidate has appeared within the last few days in the person of Dr. D. B. Mahon, of Ballinrobe, co. Mayo, a member of the Poor-law Medical Service. Dr. Mahon was an energetic member, if not the actual founder of the co. Mayo branch of the Association, a branch which was actively associated with a most energetic effort made some few years ago to instil new life into the Association. This effort succeeded for a time and gave promise of leading to important and permanent reform, but it was unfortunately nullified by the disloyalty of members of the profession to their own interests, and has now been swamped by the schemes and quarrels of the last year. If the Poor-law medical officers really desire a provincial candidate, they have thus got a choice between two men who were each actively concerned in the last real struggle of the Irish Medical Association for betterment. It is needless to say that Dr. Mahon is supported by the members of his branch, who consider that, "while the thanks of the Poor-law officers are due to Sir William Thomson for his efforts on their behalf, so many portals exist for his admission into the General Medical Council that it is unlikely that that body will be for long without his assistance in the event of his non-election as direct representative." As we mentioned in our last issue, the Ulster Medical Society has decided to support the candidature of Dr. Leonard Kidd.

The Co-operation of London Medical Schools.

THE question of the concentration of the teaching of the Preliminary and Intermediate subjects of the medical curriculum in London at a few centres, has long occupied the attention of those interested in medical education, as it has been felt that this step *must* result in greater efficiency in teaching, as well as in economy of expenditure. The Westminster Hospital Medical School has been the first to take definite action in the matter, and has just completed negotiations with King's College, by which arrangements have been made for the joint teaching of physics, chemistry, biology, anatomy, physiology and materia medica (that is to say, the subjects of the Preliminary and Intermediate Examinations) at King's College. Students will enter Westminster Hospital Medical School as in the past, and will remain Westminster men, and will not become matriculated Students of King's College. We are informed that the new scheme will come into effect at the commencement of next Winter Session in October. At the same time the Westminster School is thoroughly re-organising the teaching of the

subjects of the final examination. It is believed that the more general concentration of the teaching of the preliminary and Intermediate subjects of the curriculum cannot fail to promote the best interests of medical education in London. This departure, therefore, will be one of considerable interest to all concerned.

The Fate of the Irish Medical "Directory."

WE publish elsewhere a letter from Dr. Leonard Kidd, the late President of the Irish Medical Association, in which he states that the Council of the Association, at its last meeting, passed a resolution prohibiting any further issue of the "Directory" until it had received the approval of the Council in every detail. It is not quite clear from this whether the words, "further issue," apply to the "Directory" for 1905, or only to its further issue in another year. We hope and trust that the former is the correct meaning, and that the sale of the work to the public has been finally stopped. If this has been done, it will to some extent free the Association from the disgrace of being associated with a "boycotting list," and will, at all events, show that, as soon as it became acquainted with the real character of its alleged offspring it immediately disowned it. Commendable as is this step, the Association has still another duty to perform, and it owes some reparation to the large majority of the profession who have been slandered by omission. We understand that some weeks ago an undertaking was given to the Committee of Council of the Association to the effect that a circular would be sent to each member of the profession in Ireland explaining the circumstances under which the "Directory" was published, and expressing regret. If this undertaking was given, it has not been carried into effect, and therefore we feel it incumbent upon us to point out to the Council of the Association that, though to lock the door after the steed is stolen and to keep it locked may save future thefts, it does not restore the horse to the owner, and that, as the Council is unable to give back this year the qualifications and appointments which have been filched from their owners in a "reliable and accurate directory," it at least owes an apology to them.

The Annual Extra-Metropolitan gathering of the Otolological Society of the United Kingdom will take place on June 3rd at Manchester. By permission of the Vice-Chancellor the meeting will be held in the Pathological Theatre of the Victoria University.

THE third Annual General Meeting of the Society for the State Registration of Trained Nurses will be held at the Medical Society's Rooms, 11, Chandos Street, Cavendish Square, W., on Friday next, May 26th, at 3 p.m., when, after the usual business of the meeting, an address will be delivered by Mr. R. C. Munro Ferguson, M.P., on Parliamentary Procedure in relation to the Passage of Bills into Law.

PERSONAL.

H.R.H. THE PRINCE OF WALES has graciously accepted the Honorary Fellowship of the Royal Medical and Chirurgical Society.

DR. W. H. ALLCHIN has resigned the post of Senior Physician at Westminster Hospital after a period of tenure of some thirty years.

DR. W. A. WILLS has resigned the post of Senior Assistant Physician at Westminster Hospital.

At the Centenary reception of the Royal Medical and Chirurgical Society on Monday last, Dr. Robert Barnes, of Eastbourne (retired), Dr. Gaskell, F.R.S., of Cambridge, and Dr. Bauer, of Copenhagen, were elected Honorary Fellows of the Society.

PRINCESS HENRY OF BATTENBERG and her daughter, accompanied by Sir Frederick Treves, Bart., F.R.C.S., paid a surprise visit to the London Hospital on Monday last, and were shown through the new out-patients' departments and several wards of the hospital by the Hon. Sydney Holland.

A NEW novel by Dr. S. Weir Mitchell, which the author looks upon as his best, has recently been published. It is entitled "Constance Trescot," and is described as a thrilling, romantic story of the Reconstruction period.

PROFESSOR SAUNDBY, of Birmingham, has been elected Consulting Physician to the West Bromwich District Hospital.

DR. MAGUIRE will deliver the opening lecture of the summer session of the Hospital for Consumption and Diseases of the Chest, Brompton, on Wednesday next, at 4 p.m., the subject being the elements of prognosis in pulmonary tuberculosis, with illustrative cases.

A NEW operating theatre has been presented to the Exeter Hospital by Mrs. Nosworthy, who has contributed £1,500 for the purpose.

SIR HUGH ADCOCK, C.M.G., has been appointed by the Shah Persian Consul-General at Florence. Sir Hugh Adcock is an old student of Guy's Hospital, a Member of the Royal College of Surgeons of England (1871), and a Licentiate of the Royal College of Physicians of Edinburgh (1869). He retains the rank of Honorary Consulting Physician to His Majesty.

News has been received of the death of Dr. Mizzi, the well-known leader in Maltese local politics.

The annual dinner of the Epidemiological Society will be held at the Grand Hotel, Trafalgar Square, on Friday, June 30th, when the chair will be taken by the President, Dr. B. A. Whitelegge, C.B., F.R.C.P., H.M. Chief Inspector of Factories.

The Lord Mayor will preside at a meeting at the Mansion House on July 13th, to commemorate the twenty-first anniversary of the opening of the Mary Wardell Convalescent Home by the King and Queen, then Prince and Princess of Wales.

The statue of Sir Thomas Browne which is being executed by Mr. Henry Pegram, A.R.A., is now well advanced, and it is intended that it shall be erected and unveiled in its position in the Haymarket, Norwich, on October 19th of this year, that being the tercentenary of Sir Thomas Browne's birth.

DR. R. H. NOOT has been presented with a handsome gold hunter watch as a wedding present, and a testimonial on his retiring from the post of Senior

Assistant Medical Officer at Broadmoor, with which institution he has been connected for upwards of seventeen years.

DR. HARVEY SUTTON, of Melbourne, has been chosen by the selection committee as the Rhodes scholar for Victoria for 1905. He had a distinguished career at the University of Melbourne, and is resident medical officer at the Children's Hospital.

The Sir William Taylor prize of 25 guineas has, for 1904, been awarded to Major W. H. Horrocks, M.B., R.A.M.C., in recognition of his distinguished practical and scientific work in connection with his article on drain flushing, as contributed to the *Royal Army Medical Corps Journal* in March, 1904, and for his work on the saprophytic existence of the micrococcus melitensis outside the body.

SURGEON-COLONEL P. B. GILES, senior medical officer instructor, on the 18th instant presided over the annual dinner of the Volunteer Ambulance School of Instruction, at the Trocadero, London.

PROFESSOR T. D. CROTHERS, the well-known editor of the *American Quarterly Journal of Inebriety*, has consented to visit England in October and deliver the first Norman Kerr Memorial Lecture in connection with the Society for the Study of Inebriety.

The Marquis of Zetland, K.T., will preside at the Mount Vernon Hospital Festival Dinner, which will be held this year at the Hotel Cecil, on Thursday, June 8th.

DR. ARCHDALL REID, amidst the duties and distractions of practice, has made time to prepare a further contribution to the biological problem of inheritance. His "Principles of Heredity" will awaken much interest and arouse considerable discussion.

PRINCESS CHRISTIAN will be present at the garden-party at the Northwood branch of the Mount Vernon Hospital, which is announced for July 4th.

DR. T. DYCE ACLAND, at the recent annual conference of the Parents' National Educational Union, opened a discussion on the most important question of "Fatigue and Rest in Public Schools."

MR. ARTHUR ATOCK, M.D., R.U.I., L.A.H., has been appointed representative of the Apothecaries' Hall of Ireland on the General Medical Council, in succession to the late Dr. Tichborne.

At the annual meeting of the Belfast and District Branch of the Irish Medical Association, the President, Dr. Byers, in the chair, it was proposed by Professor Lindsay, seconded by Dr. Robb, and passed unanimously, "that this branch disapproves of the appearance and general arrangement of the new *Irish Medical Directory*, and requests the Council of the Association to reconsider these matters in arranging for the issue of the next volume."

The Royal University of Ireland.

The following honours, exhibitions, &c., have been awarded by the Senate to candidates at the under-mentioned Examinations respectively:—

The Second Examination in Medicine.—Exhibition, Second Class (£15), William D. O'Kelly. Honours, Second Class, William D. O'Kelly.

The Third Examination in Medicine.—Exhibition, Second Class (£20), James B. Butler. Honours, Second Class, James B. Butler.

The M.B., B.Ch., B.A.O. Degrees Examination.—Exhibition, Second Class (£25), William J. Wilson, B.A. Honours, Second Class, William J. Wilson, B.A. Upper Pass, Patrick T. Cawley, John C. Hart, Thomas Laverty.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

EDINBURGH.

BUBONIC PLAGUE IN LEITH.—As we wrote last week, a case of bubonic plague has just been discovered in Leith, and it is a matter for congratulation that apparently the outbreak has been strictly circumscribed, and that there is no likelihood of the spread of the disease. The three patients in hospital continue to progress favourably towards recovery, and the contacts were liberated from quarantine on Saturday, the 20th inst. Happily the occurrence of plague did not interfere with the trade of the port, as the medical officer was able to give all vessels leaving the docks a clean bill of health. The patient who died of plague was admitted to the Fever Hospital as a case of typhoid on May 5. As the disease ran an anomalous course, and a swelling appeared in the groin, some fluid removed from this was examined bacteriologically, and found to contain plague bacilli. A few days later the wife and two children of the original patient were also admitted with febrile symptoms and bubos, which also gave the specific organism. Thus in all four the disease was of the bubonic variety. The father's case was the most severe; he died on the sixth day. One of the children, on the other hand, was so slightly affected as not to be confined to bed at the time the disease was detected. It is believed that the source of the disease was the carcasses of some dead rats with which the woman came in contact in her work in a rag store. As the infected house is near the water of Leith, which is infested with rats, steps have been taken to destroy them as far as possible; but so far no dead rats have been found. Shipowners have been directed to place fenders on all mooring ropes so as to prevent rats passing between the shore and ships, and all gangways, &c., are withdrawn at night. Two special medical assistants to the Public Health officer have been appointed, one to devote his time to house to house visitation in the infected area, and one to attend to the shipping as regards the destruction of rats and the granting of clean bills of health. The Public Health department is now prepared (1) to medically inspect all outgoing ships; (2) to disinfect where necessary, and certify accordingly, and (3) to deal with rat destruction. Continuous efforts should be made to destroy rats in ships, and it is added that any ship carrying a mongoose would probably become rat free. Short of this, fumigation with sulphur when the holds are empty is the most ready means of destruction, and the department are prepared to carry this out. It will thus be seen that there has been no delay on the part of the authorities in taking all the steps in their power to check the plague, and it seems as though their efforts had been rewarded by success.

TESTIMONIAL TO DR. MILLAR, NEWMAINS, LANARKSHIRE.—After forty years of labour in the district, Dr. Millar is seeking well-earned rest, and his retirement from practice has been made the occasion of presenting him with a testimonial consisting of a drawing-room suite and cabinet, a gold watch and chain and sleeve links, and a necklace and pendant for his wife as a token of the esteem in which he is held by his patients and friends in the neighbourhood. The presentation took place at a banquet held in Newmains, and was made by the Rev. W. Robertson, who alluded in feeling and appropriate terms to Dr. Millar's work since he came to the district. In his reply, Dr. Millar told his hearers how he had first come to the district as an assistant before he attained his majority, and how at that time he was known as the "Wee Auld Laddie Doctor." He had been up six times in one night, and had attended as many confinements in the same time; those he had assisted into the world would, if they were brought together, make a goodly army of nearly 7,000. In those early days there were no ambulances—the sick were moved in cabs or carts; operations were done at home, frequently by candle light, yet notwithstanding adverse

surroundings the results compared favourably with those of to-day. He had had more than half a hundred assistants of whom most had done well in life. Concluding, the "Old Doctor," as he is now called, thanked the donors for their magnificent testimonial; his only regret was that his retirement meant leaving them but he found that unless he did go away from Newmains he could never escape from practice. No greater testimony of the esteem in which Dr. Millar is held can be given, and we wish him all happiness and prosperity in his well deserved rest from active work.

MEDICAL TOWN COUNCILLOR FOR EDINBURGH.—The vacancy in the Town Council created by the death of Mr. Lang Todd, Convener of the Public Health Committee, has been filled up by the election of Dr. R. Robertson to the vacant seat. Dr. Robertson has been in active practice in the division for about fifteen years, and so was well known to the electors. His opponent was a lawyer, whom he defeated by some 300 votes. Dr. Robertson's candidature was entirely non-political, and he had support from all parties. There are thus now two practising medical men on the Edinburgh Town Council, Drs. Matheson Cullen and R. Robertson.

GLASGOW.

DEATHS FROM VIOLENCE IN GARTLOCH ASYLUM.—Recently the Lunacy Board of Scotland held an inquiry into the circumstances by which two patients at the above asylum were reported to have received grave injuries while being restrained. Shortly after they both died. In the report sent out by the Gartloch Asylum Committee, this matter was dealt with. The clerk had received a letter from the members of the Lunacy Board in which they said that this matter required the careful and serious deliberation of the Board of the District. They were dissatisfied with the replies of the night charge attendant and thought that he should not be retained any longer in the position. They thought the idea given in the Medical Commissioners' Memorandum was a good one that the night charge attendant should be a person of a higher position than the ordinary night attendants. The Medical Commissioners stated also in their report that they thought that no blame could be placed on the attendants of one of the patients, who was an unusually violent man, and it required the attendants to use their whole strength in restraining him from doing damage. The memorandum concluded the reference to this case thus:—"We are fully aware that it is easy to be wise after the event, and that there may always have been the hope that the patient would settle down, but we consider it right to make these criticisms in the hope that they may usefully guide ourselves and others in dealing with similar cases." As regards the other patient, the report of the Commissioners was as follows:—"The result of the *post-mortem* examination gives a worse appearance to this case than we were at first led to believe. The fact that the ribs of paralytic patients are more fragile than those of ordinary persons does not apparently explain the injuries, for there were deep-lying muscular contusions, internal injuries of the windpipe, and of the chest, which could only have been caused by direct violence of a brutal and wholly unnecessary kind. We regret extremely that the perpetrators of this outrage have not, owing to paucity of evidence, been brought to justice."

EAR HOSPITAL, GLASGOW.—At the above hospital in Elmbank Crescent, on the 18th inst., the twenty-fifth annual meeting was held. The chair was occupied by Dr. Robert Gourlay. The report presented by Dr. Thomas Barr, stated that the daily attendance of patients was about 45. It made special reference to the number of children, about one-third of the whole, many of whom were treated for deafness caused by mouth breathing on account of some obstruction in the nose. Of 600 school children that Dr. Barr examined at two Board Schools, 25 per cent. suffered more or less from defective hearing, often caused by faulty breathing. Taking into account these facts about the school children, it was with satisfaction that

he, Dr. Barr, looked forward to being able to welcome at an early date a member of the School Board on to their staff of directors.

Correspondence.

"IRISH MEDICAL DIRECTORY." 1

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—As the "Irish Medical Directory" has given offence to many members of the profession, and I, as a candidate for the honour of the direct representation of Ireland on the General Medical Council, have been challenged to express my views on the matter, I beg leave to say the "Directory" was never at any time submitted to the Council for their approval, and that its publication was never authorised by the Council.

At their last meeting the Council, on my suggestion, passed a resolution prohibiting any further issue of the "Directory" until it had received their approval in every detail.

This should be ample evidence that the Council do not approve of the book in its present form, and a sufficient guarantee for the respectability of future editions.

I am, Sir, yours truly,

L. KIDD.

Member of Council, I.M.A.

Enniskillen, May 21st, 1905.

[We thank Dr. Kidd for this very welcome announcement, on which we comment elsewhere.—ED.]

THE KING'S FUND AND THE MANAGEMENT OF HOSPITALS.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—With much of the excellent leader in your issue of May 17 I quite agree. At the same time, I think that the authorities of the Jubilee Hospital have not much to complain of. They appealed "unto Cæsar" while in a dilemma, and therefore in order to re-instate their institution in the confidence of the public they should abide by "Cæsar's" decision. The wholesale resignation of the Hospital staff, with the exception of two members, as occurred at the Jubilee Hospital, can only be regarded as a most serious reflection upon its management. Instead, however, of the Board proceeding to deal with the matter by taking steps to profit by the advice of their late staff, they calmly apply for candidates to fill the vacancies created and forthwith furnish themselves with a new staff as if nothing had happened. Fortunately, public opinion was too strong for the Board, and hence it was that some outside help was required in order to silence the criticism to which their action had given rise. Then it was that appeal was made to the King's Fund, as arbitrators. That the decision has been unfavourable is, perhaps, unfortunate for the Jubilee Hospital, at the same time one may safely conclude that never on any previous occasion has its management and affairs been submitted to a more crucial investigation than has just been carried out by the lay committee of inquiry. It was entirely fortunate that the committee did consist only of laymen; had any medical man been included the conclusions arrived at would have been regarded as prejudiced. You say "The King Edward's Fund is a distributing agency, and has absolutely no *locus standi* in taking over the management of any particular institution"; surely this is incorrect. The King's Fund has a *locus standi* in regard to the supervision of the management of hospitals, since it takes upon itself the responsibility of administering funds entrusted to its hands by the public, for the benefit of the institutions concerned. Obviously it would be a breach of trust were the Fund to give proportionately to every hospital without making inquiries as to the details of the management and trustworthiness of the charity. One is forced, then, to the conclusion that in the case of the Jubilee Hospital the Fund has found that nothing short of a year's management of the Institution by the Fund's own representatives will be successful in bringing the

charity into line with the other hospitals whose affairs have gained the confidence and support of this distributing agency."

I am, Sir, yours truly,

F.R.C.S.

THE QUEEN'S JUBILEE HOSPITAL.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—Your recent leader on the relations of the Queen's Jubilee Hospital and the King Edward's Fund invite some comment from the average layman's point of view. The thing that to my mind wants insisting upon is the cause of the retirement, all but two, of the late medical staff. The King Edward's Fund recommend the retirement of the newly-elected medical staff, a grotesque piece of advice that has been, naturally enough, ignored. The new staff consists of honourable men elected *coram publico*. All but two of the late staff had retired—why? Their alleged reasons are want of control over the nursing and other administrative matters. Their real reason was the impossibility of remaining on a Board of Management to which they had played false by writing privately to the Princess Louise on a general Board matter. To go behind a body in that way, I submit, is not an honourable act. That was done by all except two of the late medical staff, and after the exposure of that action there was no alternative before them other than resignation. Neither could a self-respecting Board do anything save accept the resignation of such untrustworthy members. Obviously the next necessary step was to elect a new board, which was done. Why, then these ululations? Some of them, at any rate, appear to hail from rival medical charities, and are to that extent to be discounted.

Yours truly,

A HOSPITAL FUND DELEGATE.

ASSOCIATION OF MEDICAL DIPLOMATES OF SCOTLAND.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR—I am very pleased to learn that the above Association is in full working order. As a pioneer of the idea, I wrote some letters in the *British Medical Journal* the year before last, but in my scheme the Fellows and Members were only included. I am glad the Association has included the Licentiates, as number means power.

I have never blamed the London diplomates for looking after themselves, but I do blame the Scotch diplomates for not looking after their own interests and by legal and fair means trying to remove the disabilities in medical appointments. The old saying—"money speaks"; and if all Scotch licentiates were to send their cases to Consulting Physicians and Surgeons with Scottish diplomas they would not only enable them to make a better stand for their rights, but the patients sent would argue in this wise: "I consulted Dr. So-and-So, or was operated upon by Mr. So-and-So, and found him a most skilful physician or surgeon (as the case may be). I cannot understand why the hospital I am governor of excludes Scotch diplomates. I must inquire into it." A number of such inquiries will soon set the ball a-rolling, and we should win our just rights for every member of the profession with a university degree or a higher qualification. I mention these two because I think men who aspire to hospital appointments should take the trouble to obtain one or the other.

I hope every diplomate will join in order that the funds may be sufficiently large to carry out the work successfully, of which I have only alluded to one part.

I am, Sir, yours truly,

THOMAS DUTTON.

7 Manchester Square, W.

May 19th, 1905.

"TESTIMONIAL MONGERING."

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—Our attention has been called to the article appearing in your issue of April 12th, headed

"Testimonial-mongering," in which you refer to the trade testimonials issued by a certain Dr. A. B. Griffiths, and express surprise that the Society of Public Analysts has not taken this matter up. In reference to this, will you permit us to point out that the Society of Public Analysts, like the Institute of Chemistry, does everything in its power to discourage the practice of issuing, for purposes of publication, analytical certificates dealing with commercial products, but inasmuch as Mr. Griffiths is not a member of the Society of Public Analysts, you will see that that body is not in a position to exercise any control over his actions.

We are Sir,
Your obedient servants,
ALFRED C. CHAPMAN, } Hon Secretaries
P. A. ELLIS RICHARDS, } Society of Public Analysts.
London, May 17th, 1905.

THE POSITION OF MEDICAL OFFICERS OF HEALTH.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR.—The slight sketch of the position of Medical Officers of Health presented in your last issue is unquestionably correct; a full picture would need a larger canvas and darker colouring. The whole story is most humiliating. It affords a complete demonstration of the political impotence of the profession. The abuses complained of have been conspicuous for thirty years. During all this time sanitary legislation throughout a great part of the country has been minimised or nullified; and a great body of blameless public servants have been constrained to a position of discomfort and dishonour. The profession has all along been as it still remains, unable to initiate even the first moves of reform, in spite of the fact that in the British Medical Association it possesses an organisation through which its united voice might find utterance. It is a mistake to suppose that gross neglect of sanitary laws is discoverable only in remote isolated rural districts. It would be easy to name many urban and rural districts within one hundred miles of London in which at this moment a large perfectly preventable mortality occurs annually, and especially among the children of the poor, as a direct consequence of neglect of duty by local authorities. The Medical Officers, as well as the Sanitary Inspectors, are powerless. They are often engaged and paid to give only a small portion of their time to their duties, and are unable to exercise supervision to any adequate extent, much less to make themselves fully acquainted with the minute sanitary conditions of their districts. Few of them dare expostulate in private, whilst such a thing as a public protest by an officer is almost unheard of. The forces and the resources of the British Medical Association are now absorbed almost completely in the production of a cheap weekly paper. It seems to me, at least, a great pity this great Association—great in numbers, if not at present in power—cannot be reorganised so that its proper weight as a vast body of men of the most highly educated, among professions, should be brought to bear towards the solution of problems of such supreme importance to the community and the State.

I am, Sir, yours truly,
May 18th, 1905. SANITARIAN.

Royal College of Surgeons of Edinburgh.

At a meeting of the College held on the 16th inst., the following gentlemen, having passed the requisite examinations, were admitted Ordinary Fellows:—John William Crerer, M.B., C.M., Maryport; Robert Douglas Argyll Douglas, M.D., L.R.C.S.E., Edinburgh; William James McCulloch Ettles, M.D., London, E.C.; John Smith Fraser, M.B., Ch.B., Edinburgh; Sidney Gerald Comes, L.R.C.S.E., Jesselton, British North Borneo; Duncan Gray Newton, M.B., C.M., Brook Hill, Sheffield; Stanley Raw, M.D., Sunderland; Cyrus Retallack, L.R.C.S.E., Edinburgh; Lambert Kenneth Rodriguez, L.R.C.S.E., London, E.C.; Clifford John Taylor, L.S.A., Clifton, Bristol; and John Sandison Yule, M.D., Melbourne.

THE CENTENARY BANQUET OF THE ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

THE great banquet hall of the Hotel Cecil was filled with Fellows and guests of the Royal Medical and Chirurgical Society on the evening of Monday, the 22nd instant. The occasion was graced by the presence of H.R.H. the Prince of Wales, who occupied the place of honour on the right of the President, Sir Richard Douglas Powell, Bart., and at the high table there were, among other distinguished guests and Fellows, his Grace the Duke of Northumberland, the Lord Chief Justice of England (Lord Alverstone), Lord Strathcona and Mount Royal, General Lord Chylesmore, the Bishop of Oxford, Sir William Church Bart., Sir William Huggins, President of the Royal Society, Sir Arthur Rucker, F.R.S., Sir Thomas Barlow Bart., Sir William Ramsay, Sir John Williams, Bart., Dr. Pye-Smith, F.R.S., and others.

The Bishop of Oxford, the distinguished son of the late Sir James Paget, a former President of the Society, said Grace.

The *recherche* menu done justice to, the President proposed the loyal toasts of the King and Royal Family, dwelling especially on the claims of H.R.H. the Prince of Wales to the homage of the Society. He mentioned the gratifying fact that His Royal Highness was the first member of the Royal Family to become an Honorary Fellow of the Society. The toasts were received with acclamation and the Prince replied in an excellent speech which had the merit of being clearly audible in all parts of the great hall, a quality which could not be said to characterise some other interesting speeches which were only audible in the immediate neighbourhood of the speakers.

The President, SIR DOUGLAS POWELL, then proposed "The Society." He rapidly sketched its historical development and the advances made in surgery and medicine during the eventful century of its existence and referred specifically to some great names which had left their imperishable impress upon their time. The toast was enthusiastically honoured.

Dr. PYE-SMITH proposed the toast of "Literature and Science," and coupled with it the names of Sir Arthur Conan Doyle and Sir William Huggins.

Sir CONAN DOYLE replied in a very humorous speech which was received with salvos of applause. He was followed by Sir William Huggins who referred to the distinguished place which had been taken in the Royal Society by members of the Medical Profession, his references to Lord Lister being vociferously hailed by the company.

Mr. HENRY T. BUTLIN proposed the health of the guests and pointed out that while Literature and Science had been duly honoured in the toasts, Art was conspicuous by its absence. He coupled the toast with the name of His Grace the Duke of Northumberland, who suitably replied.

The evening was brought to a close by the Lord Chief Justice proposing the health of the President. He referred to the occasional necessity which had arisen in his own life of being "coached" on medical topics and paid a graceful compliment to the distinguished place which Sir Douglas Powell held as being at once the President of the Royal College of Physicians and of the Royal Medical and Chirurgical Society in the Centenary year of its existence.

The PRESIDENT replied, and the company dispersed with the recollection of a most successful celebration of a memorable occasion.

It should be mentioned that an added charm was lent to the scene by the presence of ladies in the boxes which overlooked the banquet hall, dimly visible through the clouds of smoke which were thickly wafted towards the roof.

The unveiling of St. Luke's Window in St. Ann's Church, Queen Victoria Street, will take place on Monday, June 5th, at 1 p.m. A number of guests will afterwards be entertained at luncheon in the Hall of the Society of Apothecaries, Blackfriars.

Obituary.

ROBERT EDWARD CRAINE, F.L.P.S. AND L.M. GLAS.

DR. ROBERT EDWARD CRAINE, well known in the West of Fife, died at his residence in Charlestown, last week. Deceased, who belonged to Ramsay, Isle of Man, and had practised in Charlestown, Limekilns, and the surrounding district for some twenty-five years, took the qualification L.F.P.S. Glas. in 1878. He had been in failing health for some time, and the end was not unexpected.

WILLIAM OGLE, M.D., M.A., F.R.C.P. LOND.

DR. WILLIAM OGLE, another old and respected practitioner, has just died at the age of 82. Dr. Ogle was educated at Rugby under Dr. Arnold, and afterwards at St. Catharine's College, Cambridge, of which he became a Fellow. He studied medicine at Edinburgh, and took the F.R.C.P. Lon. in 1868. After holding a position on the staff of St. George's Hospital, London, he was in 1860 appointed physician at the Derby Infirmary. He held that post until the winter of 1891, when he resigned, and was placed upon the consulting staff. Of late years he had devoted himself to various religious and philanthropic works. He was made a magistrate for Derby in 1894.

LIEUTENANT-COLONEL CHARLES WHITE, A.M.S., M.R.C.S., L.S.A.

WE have to record the death of Lieutenant-Colonel Charles White, who died at 53, Carlton Hill, London, N.W., on the 9th instant, aged 64. He entered the Army Medical Department as Assistant Surgeon, March 31st, 1865; became Surgeon-Major, March 31st, 1877; was granted the rank of Lieutenant-Colonel, March 31st, 1885; was made Brigade-Surgeon-Lieutenant-Colonel, September 16th, 1891; and retired in November, 1895.

GEOFFREY RICHARD SLADE, M.D. CAM., M.A., M.R.C.P.S. ENG.

It is with great regret we record the death of Dr. G. R. Slade, at the early age of 33. He graduated M.D., M.R.C.P. and S. in 1904, and at the time of his death held the appointment of Resident Receiving Officer and Assistant Anaesthetist to the London Hospital.

DR. PETERSEN, COPENHAGEN.

THE fate of Dr. Petersen, head of the University Hospital of Copenhagen, who arrived at Aix-les-Bains last October, and shortly afterwards disappeared, is now cleared up, his body having been found near the Lac du Bourget on Mount Revard. Dr. Petersen must have fallen over a precipice, after losing his way on the mountain.

Medical News.

Midland Medical Union.

THE annual dinner of the Chesterfield Branch of the Union was held on Thursday, the 11th inst., at the Hotel Portland. Amongst those present were the President of the Union, Dr. Godfrey Macdonald, C.C., of Crich (in the Chair), Dr. J. G. Shea, J.P., of Chesterfield (in the Vice-Chair); Drs. Geo. Booth, J.P., Dr. Dyson, J.P. (Sheffield), Mr. R. J. Pye-Smith, Mr. Cheesewright, Drs. S. Worthington, J. W. Martin, Rankin, Arthur Hall, Messrs. Rowthorne, F. Edmunds, W. Stratton, A. Chawner, E. V. Sutcliffe, Drs. W. J. Symes, Connolly, A. Green, Riseley Sinclair White, Rainsbury, Duncan, Messrs. B. Loo, C. J. Palmer, and G. S. O'Rourke, LL.D. (General Secretary). After the

usual loyal toasts had been proposed and duly honoured the toast of the Midland Medical Union was proposed by Dr. Cheesewright (Rawmarsh, Rotherham) and responded to by the President. That of the Guests by Dr. Geo. Booth, J.P., and responded to by Dr. J. W. Martin (Sheffield), and Mr. Rowthorne (Rotherham). After which the evening was spent in discussion of matters relating to the objects of the Union, and an interchange of experience in attaining fair and reasonable remuneration for medical contract services by unity of action in particular districts; and a pleasant and useful evening was spent.

Trinity College, Dublin—Trinity Term, 1905.

PREVIOUS MEDICAL EXAMINATION.—*Anatomy and Institutes of Medicine*: Bethel G. H. Solomons and Arthur E. Knapp. *Physics and Chemistry*: Thomas P. S. Eves, James P. S. Dunn, and Francis W. H. Bigley.

PREVIOUS DENTAL EXAMINATION.—*Physics and Chemistry*: Charles R. Kidd and Arthur K. Macdonald.

Designs for the New King's College Hospital.

By kind permission of the Worshipful Company of Carpenters, an exhibition of the competitive plans and drawings for the new buildings of King's College Hospital, at Denmark Hill, will be held in the Courtroom of the Carpenters' Hall, London Wall, E.C., from May 26th until June 1st. The Exhibition will be open on May 26th from 12 noon until 6 p.m.; and on the five remaining days from 10 a.m. until 5 p.m., except on June 1st, when it will close at 4 p.m. Free admission to members of the medical profession on presentation of visiting card.

Cameron Memorial Hospital.

A NEW hospital has been opened at West Hartlepool, entitled the Cameron Memorial Hospital. It has been erected by the widow, sister and brother of the late Colonel J. Cameron. It has provision for twenty-five adult patients, and contains one cot. The out-patients department is extensive. £20,000 has been provided by the donors for the site, building, furnishing, and establishment.

MRS. JANE MARIA BROOKSBANK, of Sydenham, has bequeathed the Findon Village Home, near Worthing, a sum of £5,000, and each of the following institutions £105:—The Chelsea Hospital for Women, the Hospital for Consumption, Fulham Road; the Children's Hospital, Sydenham; the National Truss Society; the Brompton Cancer Hospital; the Bexhill Convalescent Home; the St. Michael's Convalescent Home, Westgate-on-Sea; the Royal Hospital for Incurables; and the British Home for Incurables at Clapham.

THE next general meeting of the Association of Medical Diplomates of Scotland will be held to-day at 11, Chandos Street, Cavendish Square, London, W., at 8.30 p.m., Clinical cases, illustrating all phases of rheumatism, will be shown. A short discussion will also be held, and a petition will be drawn up asking the Royal College of Surgeons of Edinburgh to consider the advisability of changing the title of Licentiate into that of Member, so as to come into line with the M.R.C.S. of the English College of Surgeons.

THE "Ascot" Ball, in aid of the Victoria Hospital for Children, which was to have been held on June 15th, has been postponed to June 28th.

A MEETING was recently held at Ayr in connection with the proposed Consumption Sanatorium for Ayrshire. It has been decided to proceed with the scheme. The estimated cost per bed appears to be about £337 10s.

MR. ELLIS GRIFFITHS, who is in charge of the Dog Protection Bill, recently presented a petition which he stated contained 180,000 signatures. The Bill, which seeks to protect dogs from being used for vivisection, has been supported by several enormous petitions during the session.

Notices to Correspondents, Short Letters, &c.

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

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 re-forwarding 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.

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.

A FRENCH MIXTURE.

It has been recorded that in the view of foreigners the majority of Englishmen possess the title of "sir," even as the Americans are all Generals or Colonels. In connection with the recent visit of medical men from this country to France, the description of some of the best men in names in the French newspaper is a little amusing, although amusing. Here is a clipping from *Le Lyon Republicain*:—
A côté des personnes déjà citées, nous avons noté M. M. Kôgn, directeur général du service médical des armées britanniques; Moyrhandede, O'Brien de Dublin; Haunday, de Birmingham; Sir Ling, de Manchester; Gibs in, d'Edimburg; Sir Thomson d'Oxford; Sir Clifford, de Lambridge; Keowler, Sir Dice Duckworth, etc., etc.

D. & U. R. R. (M. I. R. S.).—We regret being unable to add further to our exchange list.

B. S. S.—We understand that the gentleman in question, is a solicitor, as well as a medical practitioner.

Dr. T. B. S.—The *ex parte* statement of patients on a hardly be regarded as trustworthy. We should counsel our correspondent to make further inquiries before judging his confrere.

MEDICAL ETIQUETTE.

A **CORRESPONDENT** sent us the following information:—"The name of Mr. R. Brudenell Carter, F.R.C.S., appears on a widely circulated trade circular as Chairman of The International Exhibition Co-operative Wine Society, Limited; one of the objects of which remarkable body is said to be the purchase and importation of foreign wines and their sale at cheap rates to members." A Mr. Carter was at one time a member of the General Medical Council (now in session), our correspondent asks for an expression of opinion of that august body on this now widely advertised speculation in the interests of "the trade."

NORTHUMBRIA.—The issue containing the article by Dr. Shaw-Mackenzie on "The Treatment of Inoperable Cancer" has been sold out, and consequently we are unable to supply any more copies.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MAY 24th.

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY (29 Hanover Square, W.).—5 p.m. General and Ordinary Meeting.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY (Natural History Museum, Cromwell Road) Conversation. 9.30 p.m. Reception by the President and Lady Powell.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. J. Clarke: Clinique. (Surgical.) 5.15 p.m. Dr. C. T. Williams: Pulmonary Congestion.

ASSOCIATION OF MEDICAL DIPLOMATES OF SCOTLAND (11 Chandos Street, Cavendish Square, W.).—8 p.m. Council Meeting. 8.30 p.m. General Meeting. Clinical Cases illustrating all Phases of Rheumatism. Discussion and Position to the Royal College of Surgeons, Edinburgh, to alter the title of L.R.C.S. Edin. to M.R.C.S. Ed.

THURSDAY, MAY 25th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.). 4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Dr. R. Hutchinson: The Dietetic Treatment of Diabetes.

FRIDAY, MAY 26th.

CLINICAL SOCIETY OF LONDON (20 Tavistock Square, W.).—8.30 p.m. Annual meeting for the Election of Officers and Council for the Sessions, 1905-06. Papers:—The President (Dr. F. Taylor) and Dr.

Fawcett: A Case of Milky Asites in which the Opalescence was not due to Fat.—Mr. J. Berry: A Rhinoplastic Operation.—Dr. B. Phillips and Mr. B. H. Spillbury: A Case of Primary Adrenal Carcinoma of the Liver (specimen and microscopic section).
MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.). 4 p.m. Dr. D. Grant: Clinique. (E.C.)
NORTH-EAST LONDON POST GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Lecture-Demonstration: R. P. Brooks: S. M. New Ophthalmic Remedies.

MONDAY, MAY 29th.

NORTH-EAST LONDON POST GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Dr. A. J. Whiting: Central and Peripheral Lesions of the Spinal Cord.

Vacancies.

The Sidlaw Sanatorium, Auchterhouse.—Medical Superintendent. Salary £250 per annum. Applications to Wm. H. Blyth Martin, Hon. Secretary, City Chambers, Dundee.
Coventry and Warwickshire Hospital. House Surgeon Salary £100 per annum, with rooms in the Hospital, board, washing, and attendance. Applications to Ellis E. Risip, Secretary, Coventry Sanatorium for Poorer Consumptives, Winaley, near Bath.—Resident Medical Officer. Salary £200 per annum. Applications to the Secretary, 81, Park Street, Bristol.
Borough of Harrogate.—Superintendent and General Manager of the Corporation Wells and Baths.—Salary £300 per annum. Applications to the Chairman of the Wells and Baths Committee, Municipal Offices, Harrogate.
Chester General Infirmary. House Physician. Salary £90 per annum, with residence and maintenance in the house. Applications to the Chairman of the Board of Management, Secretary's Office, 29 Eastgate Row (North), Chester.
Metropolitan Asylums Board at the Fever and Small-Pox Hospitals.—Male Assistant Medical Officers. Salary £180 per annum, with board, lodging, attendance and washing. Applications to the Clerk, Metropolitan Asylums Board Embankment, London, E.C.
Nottingham General Hospital.—Assistant House Surgeon. Salary £100 per annum, with board, lodging, and washing in the Hospital. Applications to the Secretary.
Mill Road Infirmary, Liverpool.—Assistant Medical Officer. Salary £125 per annum, with board and apartments. Applications to Harris P. Cleaver, Clerk to the Guardians, Brugham Terrace, West Derby Road, Liverpool.

Appointments.

ALLEN, JAMES D.O., M.B., C.M. Edin., Public Vaccinator and Medical Officer to the Binfield District of the East Hampshire Union.
BEAUMONT, W. H., M.B., B.S. Cantab., Certifying Surgeon under the Factory and Workshop Act for the Sedburgh District of the county of York.
CROSS, W. FOSTER, M.B.C.S. Eng., L.R.C.P. Lond., an additional Non-Resident Anesthetist at St. Bartholomew's Hospital.
GRAY, WALTER GORDON, L.R.C.P. Lond., L.M. Edin., M.R.C.S., Medical Officer of Health for the Holsworthy (Devon) Urban District Council.
LAWSON, T. C., M.R.C.S., L.S.A., Certifying Surgeon under the Factory and Workshop Act for the Stokenchurch District of the county of Buckingham.
LOCK, JOHN LEWIS, M.A., M.B., B.C. Cantab., M.R.C.S., L.R.C.P., Medical Officer of Health of the Uxbridge Urban District.
MANBY, W. R., M.B. Cantab., Certifying Surgeon under the Factory and Workshop Act for the Bridport District of the county of Dorset.
SAUNDAY, ROBERT, M.D. Edin., F.R.C.P. Lond., Consulting Physician to the West Bromwich District Hospital.

Marriages.

GOWER-GREER.—On May 19th, at the Presbyterian Church, Ballymoney, Ernest Arthur, younger son of Sir William R. Gower, M.D., F.R.S. of 60 Queen Anne Street, London, W., to Constance Macgregor, elder daughter of Thomas Macgregor Greer, of Ballymoney, co. Antrim.

Deaths.

JACKSON.—On May 21st, at 24 Broadhurst Gardens, South Hampstead, Sydney Druce, son of John Thomas Jackson, M.R.C.S. in his 46th year.

SLADE.—On May 16th, at the London Hospital, Geoffrey Richard Slade, M.A., M.D., M.R.C.P., aged 33 years.

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The Medical Press and Circular.

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WEDNESDAY, MAY 31, 1905.

No. 22.

Original Communications.

COLLES'S FRACTURE

AND OTHER FRACTURES AND DISJUNCTIONS AT THE LOWER END OF THE RADIUS AND ULNA.

By ANDREW FULLERTON, B.Ch., F.R.C.S.I.,
Hon. Assist. Surgeon to the Royal Victoria Hospital and to the
Belfast Hospital for Sick Children; Examiner in Surgery, Royal
College of Surgeons, Ireland.

THE term "Colles's fracture," strictly speaking, ought to be confined to those fractures of the radius close to the wrist-joint, in which displacement of the lower fragment backwards occurs. It has, however, been loosely applied to all fractures of the radius in the vicinity of the wrist-joint whatever the displacement may be. According to Stimson, it was first described by Pouteau in 1783. A vast amount of work on injuries in this region has been done by a number of British, American, and Continental observers, whose names are well-known in surgery. Colles, R. W. Smith, Gordon, and Bennett have upheld the honour of this country, and no work on fractures can be considered complete without a reference to their writings. In this paper I propose to analyse seventy cases that have been under my care for the last thirteen months with reference to—their causation; the age at which most frequent; the sex; the side affected; the position and line of fracture; the implication of the ulna; the presence or absence of impaction; the presence or absence of comminution; the displacement of the fragments and consequent deformity; the complications; and lastly, the treatment. Eleven were examples of disjunction of the lower epiphysis of the radius and these will require a separate short notice.

Causation.—It is stated in all the books treating of Colles's fracture that the accident is produced by falling on the outstretched hand, but the exact position of the hand is, I believe, correctly described by Erichsen (1), who says: "When a person falls on his hands outstretched to save him, the limb is usually not completely pronated. It is half way between complete pronation and the mid-state between pronation and supination. Complete pronation is a forcible muscular effort which is not carried to the full extent at the moment of danger. The hand is, in fact, three-quarters pronated. The effect of this position is, that the ulnar border is directed slightly downwards and first comes into contact with the ground and the fracturing force is directed in a line that is somewhat towards the radial side, as well as backwards and upwards." When both bones are broken at the same level near the wrist, it is possible that the cause may be a fall on the wrist or lower end of the forearm rather than upon the outstretched hand, but upon this point I have not sufficient evidence.

When the hand is in the mid-position between pronation and supination and the patient falls on the ulnar border alone, a form of displacement is produced, of which I have a number of skiagraphs, namely, radial

displacement of the lower fragment with slight or perhaps no dorsal deformity. It is to the treatment of these cases that I shall presently specially direct attention, in view of the fact that permanent deformity is very liable, if not certain, to ensue. When a patient falls on the back of his hand he may fracture his radius at its lower end and the fragment may be displaced forwards instead of backwards. I have, in the series referred to, one case of this class. (Fig. 10) and it resembles very closely a case recorded and illustrated by E. H. Bennett (2).

Does a fall on the back of the hand ever produce a fracture with the ordinary dorsal displacement? Hamilton (3) mentions an exceptional case in the person of a lady who fell in getting out of a street car, striking the back of her hand while the hand was shut. The displacement was in the same direction as in cases caused by a fall on the palm. R. W. Smith (4) says, Colles's fracture may be produced "by a fall either upon the palmar or dorsal surface of the hand." He is not now referring to the anterior displacement, which he describes later as "generally the result of a fall upon the back of the hand." It is conceivable that a simple unimpacted fracture may occur, and that the backward displacement may be produced by muscular action or by attempting to rise after the accident by putting the palm to the ground. Several of my patients volunteered the information that they fell on the back of the hand, but only in one was forward displacement present. The others had the ordinary dorsal deformity. In one case there was an abrasion on the back of the hand to confirm the history. One sustained a fracture of the radius in raising a weighty parcel, supporting it with the palm. Dorsal displacement of the radial fragment and fracture of the ulnar styloid were present. Another fell against a wall. An unusual method is the following: A steam-hammer struck an iron tool, 5 ft. long, with which a man, *æt.* 38, was working. The opposite end was thereby tilted up and struck him on the palm of the hand, driving the latter backwards. On examination there was a fracture of the radius about $\frac{1}{2}$ in. from the tip of the styloid which showed, by skiagraph, evidence of comminution. The ulnar styloid was also broken. Crepitus was easily obtained at the seat of the radial fracture.

Age and Sex.—Most of the text-books (5) on surgery state that Colles's fracture is more common in women of an advanced age. In my series, excluding the 13 cases of disjunction of epiphyses, one of fracture of the styloid process of the ulna alone as a complication of dislocation of the carpus backwards, and one of fracture of the posterior margin of the articular surface of the radius as a complication of dislocation backwards and fracture of the scaphoid, there are 57 cases, and in all the age of the patient is mentioned. Four cases occurred between the ages of 9 and 23 years, 17, between 30 and 40 years, 14 between 40 and 50 years, 12 between 50 and 60 years, 9 between 60 and 70 years, 1 at 70 years.

That is to say, 54 per cent. of the cases occurred between the ages of 30 and 50, and only 38 per cent.

after 50. The largest number of cases (17) occurred between the ages of 30 and 40, and, curiously enough, 12 of these were males and 5 females, although taking all the cases together the numbers were 28 males and 29 females. Of the 29 women, 14 or nearly 50 per cent. were between 50 and 70, while among the 28 men there were only 7 cases or 25 per cent. over 50. In the men, therefore, 75 per cent. of the fractures occurred before the age of 50. This frequency in men before the age of 50 would probably be accounted for by the fact that this is a large manufacturing city with shipbuilding and other works, where men in the prime of life are employed, and where falls are very frequent into holds of vessels, from ladders, from windows, and in many other ways.

The Position and Line of Fracture.—Colles (6) in 1814, in describing the injury, says "the fracture is situated about $1\frac{1}{4}$ in. above the carpal extremity of the radius." Smith states that he has never seen it more than 1 in., and that in the majority of cases it is not so much. He also states that in several specimens it was within $\frac{1}{2}$ in. of the extremity. Gordon gives the extremes as $\frac{1}{4}$ and 2 inches. Hamilton agrees with Dupuytren in describing the fracture as occurring from 3 to 12 lines above the joint. In my own cases, in 35 of which the position (as estimated from the skiagraphs) is mentioned, 14 were $\frac{3}{4}$ in. or less, 15 about 1 in., and 5 between 1 and $1\frac{1}{4}$ in. from the tip of the styloid process of the radius along the outer margin. In one case the measurement along the outer margin was $1\frac{1}{2}$ in. The skiagraphs (Figs. 2 and 3) show a well-marked spike extending up the shaft for an unusual distance on the outer side. There is a shorter spike on the inner side. This gives an erroneous appearance of impaction which was certainly absent. The lower fragment was comminuted. These skiagraphs also show well an obliquity from side to side and from above downwards of the line of fracture. In 29 cases therefore out of 35 (82 per cent.) the fracture was situated 1 in. or less from the tip of the styloid process of the radius along the outer side. On the inner side several of the fractures approached to within $\frac{1}{2}$ in. of the wrist-joint. Probably most cases of Colles's fracture are situated within the last inch of the radius.

The reason for this will be readily understood by a study of sections of the radius (see Fig. 1). In one set the bones are sawn transversely parallel to the anterior surface and in the other from before backwards parallel to the outer surface. It will be seen in the first set that the compact bone terminates rather abruptly almost exactly one inch above the tip of the styloid process on the outer side. On the inner side it comes further down, and terminates about the margin of the articular surface for the head of the ulna about $\frac{1}{2}$ inch from the end of the bone. In the second set the compact layer descends on the posterior surface of the radius to within about half-an-inch of the joint, while on the anterior aspect it descends a couple of lines further down. This arrangement accounts for the frequent obliquity of the fracture both from behind forwards and from without inwards as described by Gordon, and as exhibited in many of my skiagraphs. Gordon, however, attributes the obliquity to the presence of the supinator spine externally, and the ridges on the bone posteriorly which, he says, strengthen these parts and determine the line of fracture. Smith says the fracture is usually transverse and Voillemier supports him in this. As a matter of fact, by referring to skiagraphs it can be seen that an obliquity from without downwards and inwards is quite common. In some cases the fracture begins at the junction of the compact tissue with the thin layer over the cancellous tissue at the inner side, and, running outwards, ascends abruptly so as to form a tongue-shaped spike attached to the lower fragment at the termination of the compact layer on the outer side (Figs. 2 and 8). This tongue-shaped process is a marked feature in many of the skiagraphs of my cases, and may be due to the presence of the spine for the insertion of the supinator longus. A small spike is sometimes

seen on the inner side also (Fig. 2). The antero-posterior obliquity is not so easy to see, but several of the laterally taken skiagraphs give evidence of its presence (Fig. 3). In some cases, however, the obliquity appears to be from behind forwards and upwards, instead of the usual form, namely, from behind forwards and downwards. The observations of Smith and Voillemier were chiefly conducted on museum specimens, and they have not the same value as a study of recent preparations would have.

In two skiagraphs taken by Mr. Lane Joynet, of Dublin, and kindly lent to me by him, the styloid process of the radius is shown broken off along a line which involves the joint at its inner extremity and takes off with the process most of the carpal articular surface. The ulna in both these cases is unbroken. (See Fig. 9.) In another case under my own care the skiagraph shows the ulnar styloid broken off, tearing part of the head of the bone with it. The radial styloid is also broken off, taking with it part of the posterior and external surfaces of the bone and involving the joint. The inner two-thirds of the anterior border of the lower articular surface of the radius is apparently intact. The fracture was impacted and was probably caused by the sudden impact of the carpal bones against the posterior border of the lower articular surface. The results of treatment were very satisfactory.

The Implication of the Ulna.—The older surgeons mentioned stretching or rupture of the internal lateral ligament of the wrist-joint, but most of them seem to have failed to observe the fracture of the styloid process which is a very frequent concomitant of injuries at the wrist-joint. Thus Hamilton (7) says, "Nélaton observes that all the varieties of this fracture are often accompanied with fracture of the styloid apophysis of the ulna, and with tearing of the triangular ligament." He (Hamilton) is "not aware that any other writer has made the same observation," and thinks that "the accident is not so common as the remark of Nélaton would lead us to suppose." Smith attributes the severe pain often felt below the head of the ulna to stretching of the internal lateral ligament. Speaking of the usual deformity, he says (8) "the presence of this deformity pre-supposes the integrity of the lower extremity of the ulna and the inferior radio-ulnar connections. I hope to prove that Smith and Hamilton were in error in regard to this matter, and that "the integrity of the lower extremity of the ulna, and the inferior radio-ulnar connections" is frequently disturbed. (Figs. 2 and 6.) E. H. Bennett (9), of Dublin, says, "I am convinced that in all the fracture occurs." Scudder (10) states that "a fracture of the styloid process of the ulna . . . occurs in about 50 to 65 per cent. of all cases." Gordon in his lectures at Queen's College, Belfast, also drew attention to this complication.

In 47 cases of my series in which the presence or absence of fracture of the ulna is mentioned, 3 occurred at the same level as the radial fracture (Fig. 8), and in 23 the tip or base of the styloid process was broken as verified by skiagraph. Of these 47 cases, 44 were what are usually described as Colles's, and in 23, or 52 per cent., the ulnar styloid was fractured. In some of these the tip was torn off, in some the whole process, and in some a small portion of the ulna in addition. I believe that there are two factors at work—the internal lateral ligament which tears off the tip, and the triangular fibro-cartilage which produces fracture near the base.

In the New Sydenham Society's Atlas of Pathology (11), it is stated that "the styloid process of the ulna may be broken off at its base by the traction of the triangular ligament." I have noticed in several cases a wedge-shaped space with the base towards the ulnar side between the partially detached styloid process and the ulnar head. The process of bone is often much displaced to the radial side (Fig. 2). This fracture may occur in other injuries at the wrist-joint. Thus, in a case of dislocation of the right carpus backwards recently under my care, the skiagraph

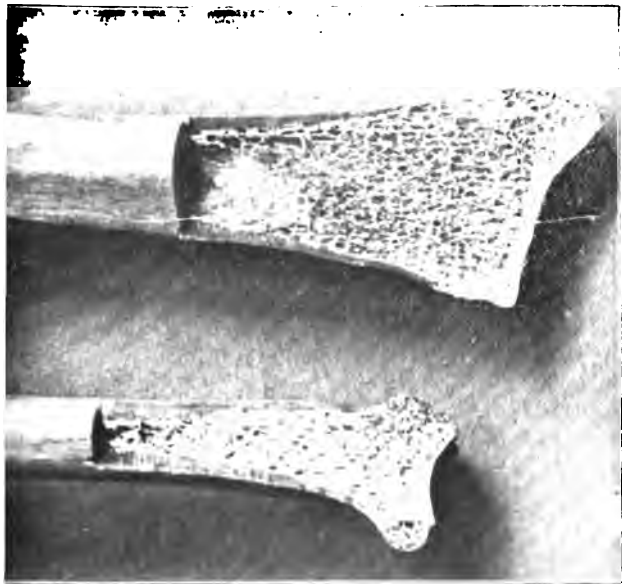


FIG. 1.—Photographs of sections of the radius from side to side and from behind forwards, showing termination of compact layer. (Natural size.)



FIG. 2.—Showing obliquity of line of fracture and spikes on inner and outer side. Also fracture and displacement of ulnar styloid.



FIG. 3.—Same case, showing obliquity of line of fracture from above downwards and forwards. Taken laterally after reduction of dorsal deformity.



FIG. 4.—Showing rotation of fragment on transverse axis.



FIG. 5.—Showing well-marked impaction.



FIG. 6.—Showing comminution, widening of interosseous space, and fracture of ulnar styloid.



FIG. 7.—Showing displacement to the radial side and rotation of lower fragment on antero-posterior axis.



FIG. 10.—Showing displacement forwards of lower fragment.



FIG. 8.—Showing fracture of both bones at same level.



FIG. 11.—Showing well-marked dorsal displacement.



FIG. 9.—Showing fracture of radial styloid.



FIG. 12.—Showing fracture of ulnar styloid in a case of epiphyseal separation in a boy æt. 17.

TO ILLUSTRATE MR. FULLERTON'S PAPER.

showed the ulnar styloid fractured. It is probable that the slight prominence of the head of the ulna which often persists after careful reduction may be due in part to stripping up of the periosteum and consequent periostitis over the head of the bone.

The symptoms of fracture of the ulnar styloid are pain and tenderness often out of all proportion to the gravity of the condition. This pain is situated at a point just at or below the head of the ulna. Crepitus is sometimes easily obtained, but if the fragment be small or far separated, it may be difficult or impossible to elicit. I have had the opportunity of noting the results of this complication after treatment :

1. The styloid may unite, sometimes in normal position, and sometimes a little to the radial side.
2. It may remain distinct from the ulna. This is a frequent occurrence.
3. It may become thickened and enlarged.
4. It may disappear altogether. In a skiagraph taken seven years after the accident it is entirely absent. As a complication, fracture of the ulnar styloid, apart from the severe pain often resulting, is of comparative insignificance.

Impaction.—Gordon was a strong opponent of the impaction theory. He says (12) "Colles's fracture is not, nor can it be, an impacted fracture : its mechanism declares impaction to be a mere phantom of the imagination, resulting from the erroneous interpretation of pathological facts." R. W. Smith held similar views and states that "the compact structure of the shaft of the radius appears to have penetrated the lower fragment (in consequence of its having become encased in osseous matter deposited for the union of the fracture)." On the other hand, Voillemier held that all these injuries are fractures by penetration. I do not think that skiagraphy can always decide this matter, as an apparent impaction may be due to a dorsal displacement of the lower fragment, the latter being superimposed upon the upper so as to give the appearance of penetration in a skiagraph taken with the hand flat. In a laterally-taken skiagraph the shadow of the ulna and the frequent obliquity from side to side give an appearance of impaction which is not always in accordance with the facts.

The following statement occurs in the most recent article on the subject in the New Sydenham Society's Atlas of Pathology : "That the locking of the fragments is usually such that it prevents any risk of subsequent increase of displacement, and thus renders the use of apparatus for immobilisation wholly unnecessary." With this pronouncement I am unable to agree, as I shall presently explain. In my own series the presence or absence of impaction was mentioned in 45 cases. In several it was impossible to state whether it had taken place or not owing to the lapse of time since the accident allowing of the formation of callus. In two of these even after a fortnight it was possible to bring the bones into good position. In only twelve of my cases could I satisfy myself that there was marked impaction (Fig. 5). Of these, two were fractures of both bones at the same level. The effects of treatment in each of these impacted cases was such that a very useful and shapely hand resulted. While I do not deny that slight dorsal impaction may have taken place in some of the remaining fractures, I do state that it was not of such a nature as to prevent very satisfactory reduction. In some of the cases I believe that crushing of the fractured ends rather than impaction took place. This crushing causes loss of substance at the seat of fracture, and leaves some permanent deformity.

The absence of crepitus has been supposed to indicate impaction, whereas the true explanation often is that the fractured surfaces are hardly in contact on account of the displacement backwards (Fig. 11), and the rotation, as it were on a hinge, of the lower fragment (Fig. 4); and also that the tense extensors tend to prevent movement, except after the exercise of considerable force on the part of the surgeon. In several of my skiagraphs the lower fragment can be seen perched high and dry on the dorsal surface of the upper fragment.

In five of my cases there was evidence by skiagraph of comminution of the lower fragment of the radius (Figs. 2, and 6), and in all these crepitus was present.

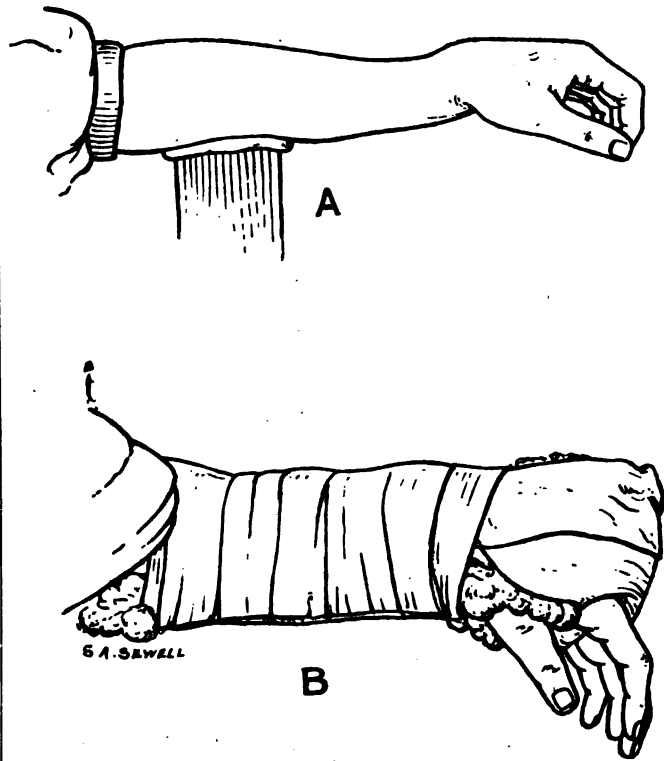


FIG. 13.—A—Dorsal displacement. B—Splints applied.

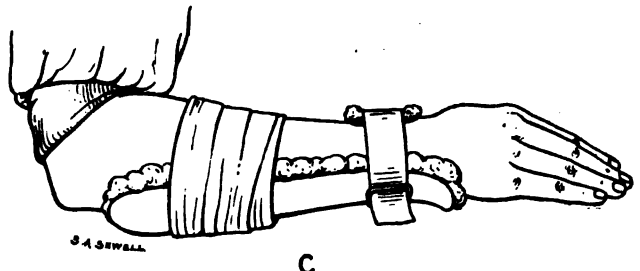
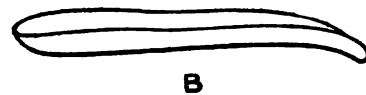
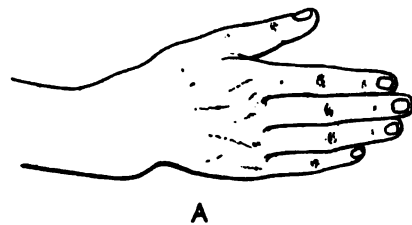


FIG. 14.—A—Marked displacement to radial side. B—Author's splint for same. C—Splint applied.

E. H. Bennett (13) believes that comminution is much more common than is usually supposed to be the case, and bases his conclusions on a large number of museum specimens. As my cases are all living, I am unable to state that fissures into the joint may not have occurred more frequently than the above figures would indicate. A fissure is often undiscovered even by the X-rays.

Displacement of the Fragments and Consequent Deformity.—In some cases there is no deformity, the only indication of a fracture being a tender spot in the usual situation after a fall on the hand. The radial styloid in these cases is not, of course, raised. In fractures of both bones at the same level the displacement is usually backwards and there is no lateral deformity. The cases mentioned in my series were comparatively easy to reduce, and remained in position with the help of splints. I have been accustomed in teaching students to classify the remaining fractures as follows:—

1. Those in which dorsal displacement is the principal feature. These are by far the most frequent (Fig. 13A).
2. Those in which the displacement outwards is most marked (Fig. 14A).
3. Those in which the displacement is forwards—a very rare form (Fig. 10).

In general terms the displacements are as follows: The lower fragment of the radius is displaced upwards, backwards, and outwards. The articular surface of the radius is rotated on its transverse axis so that instead of being downwards and forwards it looks downwards or downwards and backwards (Fig. 4). It is also rotated on an antero-posterior axis, so that the direction instead of being downwards and inwards becomes downwards or downwards and slightly outwards (Fig. 7). The various skiagraphs illustrate these displacements very well. I have already mentioned the displacement of the ulnar fragment in connection with fractures of the styloid process.

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- (3) "Fractures and Dislocations." Sixth American Edition. P. 305.
- (4) "Treatise on Fractures in the Vicinity of Joints." 1847. P. 129.
- (5) "A Treatise on Fractures." P. 455.
- (6) *Ed. Med. and Surg. Journal*, 1814, Vol. X., p. 182.
- (7) *Loc. cit.*, p. 311.
- (8) *Loc. cit.*, p. 172.
- (9) *B.M.J.*, May 22, 1880.
- (10) "The Treatment of Fractures," p. 232.
- (11) Fasciculus, XIX., 1904, p. 125.
- (12) "Fractures of the lower end of the Radius," p. 27.
- (13) Reprint on "Colles's Fracture," from *B.M.J.*, p. 1.

(To be concluded in our next.)

A SUGGESTION FOR THE OBSERVATION OF NEW PATHS IN THE SPINAL CORD.

By JAMES MACKENZIE, M.D., C.M.E.D.,
Consulting Medical Officer, Victoria Hospital, Burnley.

OUR knowledge of the construction of the central nervous system has been mainly derived from evidence afforded by dissection, by physiological experiment, and by the study of pathological changes that are found associated with some peripheral defects (as paralysis, anæsthesia, &c.). The results of accumulated knowledge derived

from these sources gives us the picture of the nervous system which is in vogue at the present time, and which, though it may be true, is far from being the whole truth. The methods employed are very rough compared with the natural working of the processes that go on within the body. Stimulation by the most delicate electrical contrivance is extremely coarse compared with the reflex stimulations that pass to these parts during the normal action of the organism. In the clinical study of patients we are daily confronted with the evidences of these delicate processes; and a field lies before every practitioner, suitable for observation, with a prospect of results so fruitful that it will in time add materially to our knowledge of the nervous system, and will modify many of the conceptions that have been arrived at by other methods. If we adopt the method of carefully noting the region of the body in which the pain is felt, some very interesting facts will be brought to light, which suggest that there are paths in the central nervous system of which we are as yet entirely ignorant. This is to be found out in noting the manner in which a pain or other sensation spreads. If one takes a drink of water a sensation of cold is felt in the epigastrium, which may descend as far as the umbilicus. Where is this sensation felt? The usual answer would be "In the stomach." But a healthy man's stomach does not reach the umbilicus. Professor Cunningham has demonstrated that the pyloric half of the normal stomach is contracted to a tube which lies across the epigastrium, usually behind the transverse colon, a position and shape quite at variance with the fanciful descriptions given in books on clinical diagnosis, but one which I have verified in the living and in the recently dead. The sensation of cold, then, cannot have been in the stomach; and if one will think of all the possibilities, one is forced to the conclusion that a stimulus has been conveyed from the stomach to the spinal cord; and certain centres being stimulated there, the individual is conscious of this stimulation, and in accordance with the law that when any part of the sensory nerve is stimulated the sensation is referred to the peripheral distribution of a nerve, the individual refers the sensation to the front of the abdomen. The sensations having reached the centres in the spinal cord or brain, what law governs their spread? We are so accustomed to think of the segmentation of the spinal cord that we might expect the sensation to spread round the body, affecting all the sensory cells in a segment. But it is manifest that there must be an easier path for the stimulus to pursue, for the sensation is felt in regions occupied by several "segments." The path must lie in a longitudinal direction, and areas in neighbouring "segments" must be more closely associated than areas in individual "segments."

The manner in which pain spreads often shows unmistakably that there must be paths in the spinal cord which are independent of segmentation. The pain of angina pectoris, for instance, may begin over the breast, pass up to the armpit and down the arm, along a well-defined path, never affecting any region except the areas in which the anterior branches of the upper four or five dorsal nerves are distributed. That these portions of nerves are affected is often manifested by the presence of hyperæsthesia over very definite regions, showing that the spinal cord has been

stimulated along a longitudinal path, and not along a transverse or segmental.

The manner in which a stimulus may pursue a longitudinal path, as distinguished from a segmental, is seen in certain cases of pain arising from strong contractions of the musculature of the digestive tract. I have pointed out that the great cause of severe cramp-like pain is the forcible contraction of non-striped muscle, the pain not being felt in the contracting muscle, but in some region of the external body wall. In watching the effect of digitalis on the human heart, I have been struck by the manner in which the drug would affect the muscle of the digestive tract before that of the heart. Thus, in one case, severe cramp-like pains were felt in the epigastrium. Gradually the pain descended into the umbilical and hypogastric areas, and when it got as low as the pubes relief was at once obtained by a free liquid evacuation. One might reasonably infer that the digitalis had set up a violent peristalsis, which had passed along the whole digestive canal. The pain felt in these areas corresponds with the results of observations I have made in the contraction of the different portions of the bowel in consequence of obstruction. It is to be noted that the pain did not follow the anatomical course of the peristaltic wave, but descended by some peculiar path in the spinal cord.

The pain arising from renal calculus pursues a path which is very definite in most cases. It raises in the back, usually in the lumbar region, and spreads forward to the front of the abdomen, slanting downwards to the groin and into the testicle. Because the ureter lies in some part of this tract, it is erroneously assumed that the stone is scratching down the ureter. In a case under my care, where the pain always followed this course, the stone was found on operating lodged in the pelvis of the kidney; and it seems to me likely that the peristaltic wave was set up in the pelvis, and as it swept down the ureter the stimulus was conveyed to the spinal cord, as in the case of the peristalsis of the digestive tube, but along a path not in relation to the centre of the abdomen, but in relation to some other well-defined path associated with the nerve supply of the ureter.

Another curious feature is the tendency of the radiation of pain and other sensory phenomena to extend in an upward direction rather than in a downward, such as in the case of heart pain already mentioned. After an attack of biliary colic, I have found the hyperæsthesia extend upward as high as the armpit, while it extended downwards only a little below the level of the liver.

GASTRIC TROUBLE

OF

URINARY ORIGIN.

By GEORGE HERSHELL, M.D.LOND.,
Senior Physician to the Queen's Jubilee Hospital.

THE symptomatic value of dyspepsia as an element of diagnosis is constantly impressed upon the physician. There can be little doubt, however, that at times its import is overlooked owing to the obscurity of the connection between the recognisable symptom and the causative underlying condition. My attention has been recently called to several striking cases in which gastric disorders can, I think, clearly be attributed to urinary

troubles. The three following cases have been selected as typical illustrations of the point in question.

Case I.—Mr. H. S., æt. 65, was sent to me on March 22nd, 1902, as a case of malignant disease of the stomach in order that I might confirm the diagnosis. About ten months previously the patient, without any obvious cause, had commenced to lose his appetite and to suffer from sensations of weight and discomfort after meals. Shortly after this he began to be troubled with nausea, accompanied on many occasions by copious eructations of gas, especially before breakfast. Six months before I saw him he vomited for the first time in his life, and had continued to do so at intervals of a day or two ever since. About the time of the first vomiting he noticed that he was losing flesh and that his appetite was becoming worse. From this time the anorexia increased, until the patient experienced an extreme repugnance to food in any form. When seen by me he was obviously very ill, being thin, sallow, and presenting an appearance which strongly suggested malignant disease.

On examination no tumour could be made out, and there was no gastric insufficiency, as the stomach was perfectly empty six hours after a mixed test dinner. After an Ewald test breakfast the total acidity was found to be only 32, free hydrochloric acid was absent, combined acid 10, the balance of acidity being made up of organic acids. The ferments were present, but reduced in amount. The fasting stomach before breakfast contained a considerable quantity of mucus tinged with bile, but no food residues.

The patient having volunteered the information that he had to get up to pass water several times a night, an examination was made, and it was found that two ounces of residual urine remained in the bladder after it had been emptied to the best of the patient's ability.

From this date the patient commenced the systematic use of the catheter, the gastric troubles gradually subsided, and in four months from the commencement of the treatment had gained eight pounds in weight, and was apparently in excellent health. No drugs of any kind were given, with the exception of urotropin.

Case II.—In January, 1903, a patient was sent up to me from the country by his medical attendant in order that I might put him through a systematic course of dieting and lavage for what was supposed to be chronic gastritis. The patient, a man, æt. 50, was suffering from continual vomiting, which had commenced six weeks previously. The vomiting usually occurred as soon as food was taken, and the stomach was in such an irritable condition that even liquids of the blandest character were at once rejected. Bismuth, morphia, oxalate of cerium, creosote, and other drugs had been tried without avail.

Upon thoroughly examining the patient it was discovered that the bladder did not empty itself, there being always about six ounces of residual urine present. This was drawn off, and the bladder washed out. The patient was fed by the rectum for a few days, the bladder at the same time being washed out daily. Liquid food was then commenced, and was retained by the patient without the slightest trouble. From this date recovery was rapid, and when last seen some months ago the patient stated that he had had no return of

the sickness and suffered no inconvenience from the daily use of the catheter.

Case III.—General G., æt. 73, consulted me in July, 1904, for vomiting and looseness of the bowels. Since September, 1901, he had suffered from enlarged prostate and chronic cystitis, the bladder trouble having been kept more or less in check by daily lavage and irrigation with nitrate of silver. He stated that for some months he had been troubled with attacks of vomiting occurring once or twice a week and with constant looseness of the bowels. At first the condition of the bowels was controlled by dermatol and careful dieting, but latterly these measures had lost their effect.

At the time I saw him a peculiarity of his symptoms was that he would remain perfectly comfortable if he limited himself to certain articles of diet in a very restricted quantity. But if he overstepped the limit by ever so little, he would first of all begin to feel uncomfortable; then would follow nausea, then acute pain in the gastric region, and lastly vomiting, which was of so violent a character, that, to use his own words, he "felt as if something would break." The attacks always terminated in several loose stools. There was considerable anorexia, a certain amount of emaciation, and the urine contained 0.06 grammes of albumin to the litre.

From my experience in similar cases I gave it as my decided opinion that the digestive trouble was dependent upon his urinary difficulty, and suggested that he should see a surgeon. He consequently consulted Mr. Freyer, who removed the prostate and two calculi on September 17th, 1904, with most satisfactory results. Not only has the patient lost his bladder trouble, but the vomiting and diarrhoea have ceased, and the patient is now eating and digesting ordinary food.

These cases are of considerable interest from the fact that the causation of the gastric derangement is frequently overlooked, and the emaciation, vomiting and loss of appetite occurring in an elderly man lead to an erroneous diagnosis of cancer of the stomach. It is a peculiarity of these cases that the growth of the urinary trouble is often so slow that it is completely overshadowed by the digestive symptoms, and the patient comes complaining of indigestion and is often quite unaware that there is anything amiss with his urinary apparatus.

It is noteworthy that the gastric symptoms often resemble in a marked degree those of cancer of the pylorus. There is the same distaste for food, the patient asserting that he has the greatest difficulty in forcing it down, and persistent vomiting is present, which in severe cases may be quite uncontrollable. A symptom, however, which should arouse our suspicions is the looseness of the bowels, which is much more frequent here than in malignant disease. Another point which may give us a valuable hint is the condition of the tongue. Slightly furred in the early stage, it often becomes red and sticky later on and presents a characteristic appearance which is difficult to describe, but which, when once seen, is not readily forgotten. In fact, it is not at all unlike the glazed tongue in certain forms of sprue.

It is well, therefore, to make it an absolute rule when engaged in the investigation of a case of chronic gastric trouble in an elderly man, always to examine the tongue, always to inquire whether

the patient has to get up at night to pass water, and where this is the case always to examine the bladder and prostate. In cases where an operation has been declined I have found the best results to follow lavage of the stomach with physiological salt solution.

The Out-Patient Departments.

ESSEX AND COLCHESTER HOSPITAL.

Senile Arterio-sclerosis with Secondary Dilatation of the Heart and Incompetence of the Mitral Valve.

By SYDNEY W. CURL, M.A., M.D. CANTAB.,
M.R.C.P.,

Physician to the Hospital.

THE patient, a man æt. 75, working as a bricklayer, but previously a sailor, came up to the hospital complaining of cramps in the calves of the legs and some shortness of breath. For some months past his health had been failing, his appetite, previously good, becoming poor, with disturbed digestion, and he had been unable to obtain refreshing sleep at night. He has had to get up several times at night to pass water, but the urine has appeared quite natural to him and there has been no pain associated with micturition. He has never suffered from rheumatism in any form nor from gout. Syphilis and alcoholic excess could also be excluded.

On examination, the following features presented themselves:—The patient is a healthy-looking man. There is no cyanosis of the lips, ears, or extremities, and no marked sign of pulmonary embarrassment. Neither venous pulsation nor venous engorgement can be seen in the neck. The radial artery is tortuous and its walls much thickened, the artery rolling under the finger like a thick piece of string. The pulse is regular and of high tension. The apex-beat of the heart is in the sixth left intercostal space just outside the nipple-line; it is well-defined and fairly strong. No thrill can be felt. The area of superficial cardiac dullness is increased in extent, chiefly to the left and downwards. On auscultation at the apex-beat a blowing systolic murmur can be heard, most audible in this position, but traceable into the axilla. The second sound is not markedly accentuated over the pulmonary area, but that over the aorta is much accentuated. No other abnormal physical signs in connection with the heart can be detected. The lungs appear normal, with the exception of slight emphysema. The liver is not enlarged and there is no ascites. A slight amount of œdema of the ankles is present. The urine contains a trace of albumin, but no casts could be found on microscopic examination. The diagnosis made was general arterio-sclerosis, dilatation of the left ventricle and secondary incompetence of the mitral leaflets. Of the arterio-sclerosis there could be no doubt; the thickened artery, high tension pulse, signs of hypertrophy of the left ventricle, and an accentuated aortic sound being quite characteristic of this condition. The mitral incompetency was considered to be the result of the arterio-sclerosis and not due to any actual disease of the valve itself, for the following reasons: There was no history of any of the common antecedents which cause disease of the mitral valve, and the symptoms, until quite recently, were not those found in cases of mitral regurgitation. The sequence of events had probably been as follows—in order to overcome the increase of peripheral resistance produced by the arterio-sclerosis the left ventricle had undergone hypertrophy, and this had increased step by step with the sclerosis of the arteries. Later, however, owing either to still further sclerotic changes in the vessels or to changes in the heart-muscle of a degenerative character, the left ventricle ultimately found itself unequal to further hypertrophy, so that dilatation of its chamber together with the mitral ring had resulted, leading to the condition of mitral insufficiency.

As to the cause of the arterial disease in this case there is no clear evidence, syphilis, gout, and alcohol,

some of the commonest antecedents, being thus excluded. Possibly, the condition in such advanced age may be looked upon as merely an exaggeration of those degenerative changes which, in the arteries as well as in other organs of the body, tend to take place in old age. In addition to the cardio-vascular changes in the patient, interstitial changes were most likely present in the kidneys also. This is suggested by the symptoms and by the knowledge of the fact that arterio-sclerosis and sclerosis of the kidneys are commonly associated, whichever be the primary affection.

With regard to the treatment of such a case, the indications are to give the heart as little work to do as possible by enforcing rest in the recumbent posture, and to administer such cardiac tonics as strychnine and arsenic with a view of enabling the heart to recover itself sufficiently to prevent the regurgitation of blood from the left ventricle into the auricle by a better adaptation of the mitral leaflets. The rest of the treatment is symptomatic, and as such is to be carried out on general medical principles.

Transactions of Societies.

ROYAL ACADEMY OF MEDICINE IN IRELAND. SECTION OF SURGERY.

MEETING HELD FRIDAY, MAY 12TH, 1905.

THOMAS E. GORDON, F.R.C.S., in the Chair.

EXHIBITS.

MR. WHEELER exhibited (a) patient upon whom he had performed the Talma-Morrison operation; (b) portion of small intestine removed from a strangulated hernia; (c) transfusion apparatus.

MR. J. L. KEEGAN exhibited (a) patient after wiring operation for fractured patella; (b) gangrenous cæcum removed for volvulus; (c) malignant stricture of the rectum.

Major HOLT, R.A.M.C., exhibited (a) aneurysm of the innominate artery; successful ligature; death from tuberculosis fifteen months later; (b) aneurysm of the innominate artery; unsuccessful distal ligature and wiring by Power and Colt's apparatus; (c) vermiform appendix, proximal end obliterated, distal end perforated; (d) fragments of a broken semilunar fibro-cartilage loose in the knee-joint; (e) kidney with multiple abscesses, and scars after former abscesses, the ureter showing scar of previous ureterotomy for calculus.

MR. R. A. STONEY exhibited (a) tuberculous cæcum, appendix and ileum; (b) goitre; (c) fibro-lipoma of the skin.

MR. PASLEY exhibited an irrigating apparatus.

OPERATION FOR CLOSURE OF THE HARD PALATE DURING THE THREE MONTHS FOLLOWING BIRTH, PRACTISED BY MR. BROPHY, OF CHICAGO.

Sir THORNLEY STOKER read a paper on the above. He had performed it in three cases, and found it so excellent that he intended to adopt it in future in suitable cases. This operation can only be practised during the period mentioned, as the bones are afterwards too fully ossified to permit the necessary change in their position. It consists essentially in drawing the maxillæ and palate bones of opposite sides together so as to close the cleft. This is done by two wire sutures passed across from one side to the other above the alveolar processes. They lie above the floor of the nasal fossæ. One is inserted behind the malar ridge, the other in front of it. The bones are forced together by pressure so as to close the cleft, the edges of which have been pared. If the bones cannot be approximated by pressure alone, the malar process is divided on each side. The anterior and posterior ends of the wires on each side are twisted together over a lead suture-plate fitted to the outer surface of the alveolus. The hard palate, the premaxillæ, and generally the soft palate are operated on at once. The hare-lip is closed subsequently when free access to the mouth for

operative purposes is not required. The wire sutures are withdrawn after about four weeks. In the main, he strongly advocated the operation, which had yielded him extremely good results, and which was not a formidable one even at the tender age of its performance. He suggested some minor points in procedure which he had found advantageous. He stated his belief that though the operation is not likely to be always one of academic perfection, yet it is on the whole an immense advance in the treatment of cleft palate, and one which cannot be overlooked and should be practised when possible.

MR. T. E. GORDON considered the risks of Brophy's operation somewhat serious, especially in those cases where it was found at first impossible to bring the edges of the palate together, and further steps were necessary.

MR. EDWARD TAYLOR stated that he had operated on a considerable number of cases by the older and better-known procedures with various modifications of his own. The all-important thing was to operate at an early age so as to secure closure of the cleft before the child began to speak. The cases he had operated on recently were from twelve to fifteen months old, and in nearly all he had succeeded in obtaining complete closure of the gap and very gratifying results as regards speech. He thought Sir Thornley Stoker's paper would afford a strong inducement to many surgeons to practise Brophy's operation.

MR. W. S. HAUGHTON said he had performed an operation very similar to Brophy's on a child nine days old. The case was one of emergency, as the child was starving. He had been struck by the ease with which the parts were brought together and with the entire absence of shock.

MR. KENNEDY alluded to the danger attending loss of blood in operations for cleft palate in young children and to the fact that in Brophy's operation the soft palate remained to be operated on after the closure of the hard palate.

Sir THORNLEY STOKER, in reply, stated that in his experience there was very much less disturbance and shock following Brophy's operation than operations performed upon older children. The operation was singularly free from risk. Mr. Kennedy evidently had misunderstood him, as he (Sir Thornley Stoker) considered the risk from loss of blood very serious, and had specially advocated a modification of Brophy's procedure to obviate it. With the exception of one case he had not deferred operations on the soft palate. In that case he found it impossible to approximate the margins of the two segments of the hard palate.

MR. J. L. KEEGAN read notes of a case of "Volvulus of the Cæcum." Mr. Kennedy and Mr. E. H. Taylor discussed the communication.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY. MEETING HELD IN THE SICK CHILDREN'S HOSPITAL ON MAY 19TH.

DR. J. O. AFFLECK, Vice-President, in the Chair.

CLINICAL MEETING.

DR. JOHN THOMSON showed (1) a child, æt. 3, suffering from chronic arthritis of Still's type of the knees, ankles, and wrists. The affected joints were swollen, comparatively painless, and restricted as to movement; the neighbouring glands, but not the spleen, were enlarged. (2) A child showing various rickety deformities, in particular old fractures of the clavicles, and bending and fracture of the forearms. The child had been in the habit of resting its weight on the arms, hence the bending. The fracture was caused in the ordinary way by the child being supported by the wrist on learning to walk, and suddenly tripping so that all its weight fell on the bones of the forearm.

DR. BURN MURDOCH showed (1) an obscure nervous case. The patient was a child, æt. 1 year 7 months, and had been fairly healthy till about a year old, when she gradually became feebler until almost the whole body was paralysed. Her muscles were very

weak and atrophied, and she could only move the limbs to a very slight extent. She could not hold her head up at all, and her thoracic respiratory muscles were equally powerless. As a result, breathing being entirely diaphragmatic, the chest was compressed antero-posteriorly and there was collapse of the posterior parts of the lungs. The reflexes were abolished, and the electrical reactions diminished. [The case corresponded more closely with Hoffman's type of spinal muscular atrophy than with any other disease. It differed from Oppenheim and Spiller's myotonia in not being congenital, and did not seem to belong to the group of muscular dystrophies. (2) A case of purpura, with severe anæmia of uncertain nature. The patient had been in hospital a year ago suffering from bad anæmia, but had recovered under iron. She had begun to suffer from purpura and increased pallor recently, and now the blood showed 1,200,000 reds, 25 per cent. of HC., and 3,000 leucocytes, mostly lymphocytes. There were practically no nucleated reds; on the body there was a profuse purpuric rash, with hæmorrhage from the mouth. It did not seem to be a case of Henoch's purpura, and might possibly turn out to be pernicious anæmia. (3) A case of congenital hypertrophy of the pylorus, in which the symptoms—vomiting, constipation, and visible peristaltic wave—had subsided under washing out of the stomach. Steady though slow gain in weight was now taking place, and the case was one of the few in which operative treatment would not be required. (4) An infant with aggravated nasal obstruction due to enlarged uvula, in which great benefit had resulted from surgical measures. (5) A case of late congenital syphilis (bossing and Hutchinson's teeth) in a girl. The patient also had mitral disease, and a curious congenital deformity known as cubitus varus. This consisted in an abnormally high position of the internal condyle of the humerus due to defective growth of the inner aspect of the bone; as a result the bones of the forearm were bent inwards at an angle.

Mr. H. J. STILES showed (1) Three cases of chronic hydrocephalus illustrating the benefits of treatment by ligature of both common carotid arteries at an interval of fourteen days. All the other operations he had tried for hydrocephalus having proved unsuccessful, he had thought of this. If hydrocephalus were not due to a mechanical obstruction of the iter, it must consist either in an increased production or diminished absorption of cerebro-spinal fluid. Whether the fluid was a transudate or an exudate, its source was the arteries, and as it could not be attacked surgically in the way of increasing the absorption on the venous side, he had thought of diminishing the arterial flow to the brain. His first case was one in which the hydrocephalus had begun at three months, and when the operation was done at five months it measured 18½ inches in circumference, and the eyes were turned downwards in the characteristic way. Now sixteen months had elapsed, the cure remained practically complete; the head measured only 21 inches, the eyes were normal, and the intelligence good. In his second case the head began to enlarge at a fortnight, and the operation was done at five weeks old, the head measuring at that time 18½ inches. Now, at nine months old, the child was quite well, the circumference of the head being 19½ inches, and the diameter of the fontanelle 1½ inches. The third case was less satisfactory. At one week old a spina bifida had been excised, and thereafter hydrocephalus developed. The spina bifida was one of those in which the central canal was dilated, but as the protrusion consisted of a hernia of the dorsal wall of the canal, it could be removed without interfering with the nerve trunks. Such a myelo-cystocele was analogous to a hydrocephalus, and little benefit had followed ligature of the common carotid three or four weeks ago. After the second operation there was unilateral sweating, protrusion of one eye, and a pin-point pupil from inclusion of the cervical sympathetic in the ligature, but as the catgut was absorbed, these symptoms passed off in about a week. (2) A boy of nine who in

1901 swallowed some lye used for cleaning brewery Casks. Three months later he had difficulty in swallowing and ultimately only liquids could be got down. In 1902 he was admitted to hospital with two strictures of the œsophagus, one 7½ inches down, and the other 1½ inches lower. These were dilated with bougies up to No. 6, and the strictures had been kept patent by occasional passage of an instrument until a few months ago, when he was again admitted on account of obstruction. As he was going down rapidly, and no bougie could be passed, gastrostomy was performed, and very soon after that soft solids were easily swallowed, showing that there had been a large element of spasm in the obstruction. The gastrostomy wound was giving rise to a great deal of irritation of the skin round it, and there had been some difficulty in getting it closed. (3) A case illustrating some points in the operative treatment of paralytic obstruction following acute suppurative peritonitis. The child was æt. 8, and had had a laparotomy performed forty-eight hours after perforation for removal of the appendix. The abdomen was not washed out at the operation, as the speaker thought there was no more certain way of killing a patient than to do so. All went well until the third day, when the abdomen became distended, and the bowels could not be opened. On opening the abdomen the sigmoid flexure was found to be collapsed, so a Paul's tube was put into the small intestine. Three weeks later the gut was resected. It was important to deal promptly with such cases. The toxæmia from the putrefying contents of the bowel was more than enough to turn the scale against recovery if they were left to Nature. (4) A case illustrating the appearance and disappearance of a multilocular cystic hygroma of the neck. Shortly after birth a mass the size of a cocoanut developed on the neck of an infant. It was decided to remove it when the child was about six months old. By that time, however, it had disappeared; as a tooth erupted it grew once more, and now had again disappeared.

Mr. E. SCOTT CARMICHAEL showed a boy, æt. 11½, after acute perforative appendicitis, with general peritonitis. The point of interest was that at the operation no less than three abscesses were found in different parts of the abdomen, to leave any one of which would have been fatal. The case showed the necessity of judiciously breaking down adhesions lest isolated purulent foci should escape notice. (2) A baby, 10 weeks old, after excision of a spina bifida, which was on the verge of rupture. No sign of hydrocephalus had as yet appeared. (3) Two children after excision of the ulna for tuberculous osteo-myelitis. The vacant space had been filled up with iodoform putty. (4) A case of extensive tuberculous disease of the frontal bone, treated by operation.

Dr. W. B. DRUMMOND showed a boy, æt. 4, suffering from interstitial keratitis. The age of onset was unusually early for this disease.

Mr. STILES showed various specimens and photographs; and Dr. CARMICHAEL showed the following—Encysted hydrocele of the cord; hernial sac and encysted hydrocele of cord; stomach after posterior gastro-enterostomy in a child, æt. 5 weeks, with congenital pyloric stenosis; appendix with polypus in its lumen; tibia five weeks after resection for osteo-myelitis, showing formation of new bone; tibia resected for osteo-myelitis; upper end of ulna resected for tuberculous disease.

ULSTER MEDICAL SOCIETY.

MEETING HELD (IN THE MEDICAL INSTITUTE, BELFAST), THURSDAY, MAY 25TH.

The President, Dr. WM. CALWELL, in the chair.

Dr. MARION ANDREWS showed a large

FIBROID TUMOUR,

removed by her three days before from the uterus of a woman, æt. 28, in the Ulster Hospital for Children and Women. The interest of the specimen lay in the early age at which it occurred, and in the difficulty in diagnosing with certainty from pregnancy.

Professor SYMMERS, the newly-appointed Professor

of Pathology in Queen's College, Belfast, gave a demonstration of the

LESIONS PRODUCED BY THE OVA OF BILHARZIA
HÆMATOBIA,

illustrating his remarks by lantern slides and pathological preparations. The latter, he explained, had been collected by him during eight years' work in Cairo. After pointing out the widespread nature of this tropical disease, and its menace to our own people by the constant importation of it from South Africa, he gave some account of it as found in Egypt, where it is about the commonest disease seen in hospital. It affects chiefly the peasants or fellaheen, who work barefooted in the mud of the irrigated fields, where no doubt the infection is acquired. In all *post-mortem* examinations where the disease was suspected the portal vein was exposed and slit, and some blood pressed out into a spoon; this was diluted with normal saline solution and the parasites looked for. It is found as a small red worm, about half an inch long, the male much thicker than the female. The very varied lesions found in the disease are entirely due to the eggs, and Professor Symmers showed photographs and preparations of the bladder, uterus, spleen, rectum, labium, colon, liver and peritoneum affected by them.

On the motion of Sir Wm. WHITLA, seconded by Professor LINDSAY, a cordial vote of thanks was passed to Professor Symmers for his highly interesting and instructive demonstration.

MEDICO-PSYCHOLOGICAL ASSOCIATION OF
GREAT BRITAIN AND IRELAND.

MEETING HELD MAY 18TH (IN THE ROOMS OF THE
MEDICAL SOCIETY OF LONDON).

DR R. PERCY SMITH, President, in the chair.

Dr. C. A. MERCIER drew the attention of the association to the remarkable state of things existing in the Youghal Asylum, Cork, and proposed the following motion:—"This association is informed that the auxiliary asylum at Youghal is being carried on under the following conditions. The staff consists, in addition to eight nuns, of eight male and five female attendants to 229 male and 149 female patients. For this population of 378 patients there is no resident physician. (In England no more than 50 can be detained in an institution without a resident medical officer.) The superintendent of the Cork District Asylum is held by the Lunacy Inspectors and the Lord Lieutenant responsible for the administration of the Youghal Asylum and for the proper treatment of the patients therein contained, but by a regulation of the committee of management he is not allowed to visit the Youghal Asylum nor to see the patients therein. This regulation, made by the committee of management of the Cork District Asylum, has been pronounced by the Inspectors of Lunatics and admitted by the Chief Secretary to the Lord Lieutenant to be illegal. This association expresses its astonishment and profound regret that treatment of the insane so retrograde and so objectionable in character should be possible, and trusts that steps will be taken at once by the proper authorities to enforce the law and to terminate so deplorable a mode of treatment of insane persons."

The motion was seconded by Dr. G. BOWER.

Dr. W. R. DAWSON (Dublin) confirmed the particulars stated in the motion and read extracts from reports of Parliament when the subject was discussed there. The motion was unanimously carried.

Dr. W. M. A. SMITH opened a discussion on the
USE OF HYPNOTIC DRUGS IN THE TREATMENT OF
INSOMNIA.

Dr. ROBERT JONES was of opinion that arteriosclerosis was a very important condition in those cases in which great mental distress prevented sleep, and he inclined to the belief that the effect of alcohol, which was used in asylums with a good deal of circumspection, was immediately to dilate the arteries in the cerebral cortex and to help sleep in that way. He had repeatedly used alcohol merely as a hypnotic, and one ex-

tremely restless patient, who had not been taking his food, was fed with a tube and given half a pint of stout twice a day with great benefit. He regarded sulphonal as a deadly poison to the neurons and believed that he had seen incurability follow the use of it.

Dr. BLANDFORD said that they all recognised the importance of regulating the digestive organs and giving medicines accordingly, but he had seen cases in which the giving of narcotic drugs had prevented the patient drifting into insanity, and he was in the habit of seeing cases at an earlier stage than those in asylums. A restless patient who was suddenly put into a comfortable padded room in an asylum was very likely to go to sleep and he would not dream of giving drugs to such an one.

Dr. FLETCHER BEACH thought that much depended on the amount of sulphonal given. Doubtless larger doses of it were given in asylums than for the treatment of nerve cases. He had never administered more than 15 grains at the bedside, and its use in cases verging upon insanity had been very beneficial.

Dr. BEDFORD PIERCE defended sulphonal, as he had found it a good friend, though he agreed that hypnotics should be very sparingly used.

Dr. T. D. SAVILL advocated the taking of the arterial tension before administering hypnotics, as most of them affected the arteries in some way.

Dr. H. CORNER believed that 90 per cent. of the cases could be treated without hypnotics by mechanical and food aids, though much depended on the nurse. He rarely gave hypnotics without regretting it.

The PRESIDENT said that he had not seen any disagreeable after-effects from hypnotics, but he had known people complain of extreme weariness and exhaustion after veronal. Dr. Jones had referred to sulphonal as a deadly poison to the neurons, but all the drugs which had been mentioned were deadly poisons to something. He thought sulphonal should not be relegated entirely to the scrap-heap. To some practitioners chloral and morphine seemed about the only drugs of that class known. Dr. Smith having replied,

Mr. G. T. HINE, F.R.I.B.A. (an honorary member of the association), exhibited and described the plans of the new London County Council asylum, projected at Long Grove, near Epsom.

In the evening the members dined together at the Café Monico.

France:

[FROM OUR OWN CORRESPONDENT.]

PARIS, May 28th, 1905.

ASTHMA AND ADRENALIN.

ACCORDING to M. Aronsohn, the painting of the mucous membrane of the nose with a solution of adrenalin (1-1000) arrests an attack of asthma in a very few minutes. It does not cure asthma, but affords rapid relief. If it were not possible to employ the solution, the following ointment might be substituted:—

Sol. of adrenalin, 20 to 60 mm.;
Lanoline, 1 drm.;
Vaseline, 1 drm.

About the size of a pea is introduced into the nostril.

DILATATION OF THE STOMACH.

Dilatation of the stomach is no longer considered as a morbid entity, but rather as a secondary affection.

In case of excess of hydrochloric acid, the following powders taken every three or four hours, according to the intensity of the symptoms, produce a rapid improvement.

Bicarb. of soda, 10 grs.;
Calcined magnesia, 10 grs.;
Sub. nitrate of bismuth, 5 grs.;
Prepared chalk, 5 grs.

Against constipation M. Sanpanet advises a glass of the following artificial mineral water:—

Phosphate of soda, 1 drm.;
Bicarb. of soda, 1 drm.;
Sulphate of soda, $\frac{1}{2}$ drm.;
Water, 1 quart.

The laxative effects of this solution are very efficacious.

The glass is taken fasting each morning for ten days in the month.

ICHTHYOL IN THE VOMITING OF PREGNANCY.

The persistent vomiting in pregnancy has been treated in divers manners, and numerous are the remedies prescribed to arrest it. The latest is that of ichthyol applied to the os, and which, according to some of my Paris confreres, acts like a charm. A mixture of glycerine and ichthyol (10 per cent.) is placed, by means of a plug of absorbent wool, in the vagina and in contact with the os. The remedy is simple and worth a trial.

ECZEMA OF THE BREAST.

In no region is eczema more troublesome than that of the nipple and its areola. It is accompanied with violent itching and oozing of serosity, which dries rapidly, forming soft and adherent crusts, which easily become detached, leaving a raw and bleeding surface. In a large number of cases treatment is slow to produce effects, and frequently it persists in spite of every means employed.

The treatment that has the best chances of success is that of extreme cleanliness. The parts should be washed with antiseptic soap, and a tannin lotion (1-100) applied as a spray. If, in spite of this treatment, crusts form, they should be removed with compresses of boiled water or poultices of starch or potato flour, made in a 3 per cent. solution of boric acid, and finally the following ointment applied once a day:—

Glycerine applied, 1 oz.;
Bicarb. of soda, 1 dr.;
Cade. oil, 1 dr.;
Lanoline, 1 oz.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, May 28th, 1905.

At the Society for Innere Medizin, Hr. Glücksmann spoke on

POLYPRAGMASIA IN THE CASE OF FOREIGN BODIES IN THE ŒSOPHAGUS.

He reminded the meeting that he had mentioned the harmfulness of too much interference in cases of foreign bodies in the œsophagus. He showed a patient who came to him two days ago with the following history. At 10 o'clock in the morning of that day she was eating some bread and butter with her husband when she suddenly became conscious of a pain about the edge of the sternum. She continued eating, however, and later on, the pain continuing meanwhile, she felt an inclination to vomit, and a few drops of blood came up with the straining. In a state of alarm she hurried along with her husband to the nearest accident station, where a consultation was held concerning the case. She was first examined with a tongue spatula; then no laryngoscope was used, but an instrument armed with a sponge was passed into the stomach. When this was withdrawn it was soaked with blood. The pain continued. Then a second instrument, a stiff sound of large calibre, was passed into the stomach, and on removing it a stronger inclination to vomit or heaving again took place and about a tablespoonful of blood came up, but the pain was the same. The patient was then told that the surgeons had felt a foreign body in the œsophagus, and they sent her for further treatment to Prof. Hermann-Krause, whose deputy sent her on to the speaker. External examination showed a subconjunctival hæmatoma and a struma; there was also pharyngitis. The laryngoscope revealed a submucous hæmatoma on the epiglottis. He did not use any instrument, as in his opinion there was no foreign body in the œsophagus, the case, more likely, being one of slight injury to the mucous membrane from a hard bit of bread-crust. The temperature was normal. In order to remove the feeling of tenderness he ordered small doses of morphia, three daily. On the patient presenting herself the following day the symptoms pointing to a foreign body in the gullet were no longer present, the hæmatoma of the epiglottis was disappearing, only a slight pain remaining at the level of the epiglottis. The case was a proof that under such circumstances conservative treatment was the best.

Hr. V. Leyden followed with an address on THE THREATENING EPIDEMIC OF CEREBRO-SPINAL MENINGITIS.

He thought the subject of interest, as it threatened to enter the city. He had himself observed some epidemics, the greatest number seen being in 1865 in Königsberg, then a smaller number in Strassburg and in Berlin. He had published the results of his studies in his "Eskrankungen der Rückenmarks," and had given the fever curves. An outbreak threatened in Berlin in 1864, but there were only a few cases.

The disease was well known in the earlier centuries, and then it became forgotten. Then it reappeared at the commencement of the nineteenth century at the time of the war in Elsass and Lothringen, and then, as now, it mainly affected the military. Then it completely disappeared, to re-appear in the early sixties. The disease was characterised by stiffness in the neck; the head could not be bent forwards, it could only be rotated; there were further symptoms of cerebro-spinal meningitis. Violent headache, vomiting, pain in the back, shooting into the extremities; sharp fever with violent cerebral symptoms, which went on to furious delirium. Three sorts were recognised: 1—The apoplectiform kind, the patients fell suddenly and were dead; 2—the medium; and 3—the milder form. The rapid case showed as a rule no pronounced features. The majority of the cases of those days had a protracted course, with remission and exacerbation. There was generally a remission at the end of a week, the succeeding exacerbations were generally less violent, but one could not yet count on a favourable issue with any certainty. Little children were also attacked. The fever was but slightly characteristic. The most threatening were the cerebral symptoms, the pain at times unbearable. The obstinate vomiting was also threatening; it readily led to inanition.

He had then said it was probably a vegetable infection. *Post-mortem* examination showed a pronounced cerebro-spinal meningitis. Very violent attacks were then seen amongst students and soldiers, in whom the autopsies showed hæmorrhagic infiltrations of the pia mater of the cerebrum and spinal cord.

The treatment, which was still worthy of attention, was anti-febrile, large doses of quinine, very little blood-letting and even then on the temples, hot baths, which, however, the speaker could not recommend on account of the great pain caused by transporting the patient to the bath. On the contrary, a most comfortable position should be found for the patient. Then ice to the head and narcotics. The speaker made free use of opium, as it was the only remedy that relieved the great pain and restlessness. The vomiting was not specially treated, but if it was prolonged and threatened danger from inanition, injections of morphia were given or opium and a carefully regulated diet. The ordinary rules were followed in convalescence.

As regarded the nature of the disease, a marked case occurred in Berlin in 1883, and at the autopsy micro-organisms were found, diplococci, very much resembling those of pneumonia. More recently this discovery had been confirmed. In 1887 followed the discovery of the coccus in the cells of the exudation, the meningococcus intra-cellularis, by Weichselbaum, especially known by the labours of Jäger, and further by the works of Marchiafava and others. The question of the excretion of the disease was not decidedly settled. The pneumococci had been ascertained to be present in 16 per cent. of the epidemic cases and in 22 per cent. of the cases of the sporadic form. The speaker had already proved in the Klinik the presence of both kinds of cocci.

WILLIAM HENRY FIELD, æt. 74, a retired grocer, died recently at St. George's Hospital, London, while under the influence of an anæsthetic, namely, a mixture of chloroform and ether. The operation to be performed was a minor one upon the nostrils.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, May 28th, 1905.

CHRONIC PULMONARY INFLAMMATION WITH HEART DISEASE.

OUR knowledge of the tuberculous origin is still in a very transitional and chaotic state, although many have formed dogmatic opinions of their own on the cause, course, and cure of the disease. Not long ago we recorded in these pages the latest theory on the subject to be a sort of hæmatic stasis in the lung that leads to a deposit of the tuberculous bacillus in the apex of the organ. This formed the nucleus of the disease, which soon spread to other parts of the organ, with ultimate death. To avert this source of infection surgical operations were performed by severing the first and second ribs at the junction of the sternum, in order to give more freedom for the expansion of the lung, and thus increase the circulation in the terminal part of the body. Reputed cases of perfect cure followed, and the operation was accepted as a preventive cure for pulmonary tubercle.

Now we have Rothschild, who apparently has been reading up Rokitsansky's pathology, telling us that stasis in the lung prevents tubercle developing, and founds his belief on Rokitsansky's experience and teaching, which was that tubercle never commenced in the lungs of a patient suffering from cardiac valvular disease. Rokitsansky assures us that in all the thousands of bodies he has examined he never met with a case of tubercle in the lung where valvular disease existed, and where the disease did exist, if the heart was affected later, it immediately checked the course of the disease. This led to the notion once prevalent that injury to the valves of the heart was the best preventive where a dangerous hereditary tendency existed. Mitral stenosis produced complete immunity from tubercle, as it reduced the venous circulation and congested the organ as in valvular lesions. Rothschild goes further and affirms that hyperæmia of the lung will improve cardiac affections. He concludes by pointing to Bier's treatment of chronic inflammation of the joints by congestive hyperæmia, which has met with such success, as well as the Liege cure for tubercle of the lung, which he avows is only passive hyperæmia of the lung as advocated by Rokitsansky.

An important point in the treatment of chronic tuberculosis was the sufficiency of the cardiac muscle; when insufficiency was established, improvement of the tuberculous condition commenced.

All other forms of chronic pneumonia he associated with a loss of co-ordination between the organ and the heart, and gave a series of examples, coming under his own observation, to prove his argument. In all these a chronic fibrous process was present as the primary cause, in which potassium iodide gave the best results.

HYDROPATHIC MISTAKES.

Winternitz gives the profession a severe lecture on the probable mistakes that arise in the water treatment. The first important point in the hydro treatment is the proper selection of temperature, the intensity of the mechanical stimuli, with the duration and quantity to be administered. It is supposed that each case is clinically analysed and the dietary properly arranged. In febrile diseases the temperature selected is often too low, while in the anæmic, chlorotic, and convalescent it is too high. In those prone to collapse cold compresses to the body with friction to hands and feet with warm applications are essential. In the anæmic, high temperatures with mechanical nerve stimuli frequently applied at short periods will produce the best results. In the case of those taking *sitz* baths the parts not exposed to the water should be well covered to prevent undue loss of heat. Where a combination of heat and cold is to be applied more care is necessary, and can only be carried out successfully on strong patients.

RÖNTGEN DIAGNOSIS.

Jaksch, Prague, has raised the important question

of Röntgen diagnosis in hospital clinical instruction, and maintains that it should form one of the methods of examination at the bedside. Lung diseases, such as tubercle, pneumonia, pleuritic effusion, pulmonary tumours, and cardiac affections, can all be distinguished with its assistance. Many other authors and teachers hold that Röntgenology is unnecessary in the domain of internal medicine and should therefore not be made imperative on students, as all these morbid changes can easily be diagnosed more accurately by physical methods, while the therapeutic worth of the rays is still in a state of chaos.

Operating Theatres.**ST. THOMAS'S HOSPITAL.**

OPERATION FOR TUBERCULOUS DISEASE OF THE APPENDIX AND CÆCUM.—Mr. BATTLE operated on a married woman, æt. 28, who had been admitted complaining of attacks of pain in the right side of the abdomen; these, she said, had been very frequent in character, and had lasted for a long time. One year ago she underwent an operation for relief of this pain at another hospital, and there was at the present time a scar to be found above the right Poupart's ligament. On inquiry it was found that some tuberculous glands had been removed; no improvement followed that operation, and she had suffered from pain more or less ever since. She was said to have passed blood *per rectum* mixed with *faeces* occasionally, until a fortnight ago. On admission she was a thin woman with a hectic appearance, she still complained of pain in the right side, and on deep palpation a firm sausage-like swelling could be felt in the right iliac region; the swelling was not movable. At the operation, which was carried out through an incision in the abdominal wall, combined with temporary displacement of the rectus muscle, the appendix was found very much thickened and rigid, and adherent to the cæcum; this again was a good deal thickened, diminished in size, and somewhat bound down to the iliac fossa. An attempt to separate the appendix from the cæcum caused a tear in the wall of the latter, through which the finger was then passed, and the intestine explored. The mucous membrane was irregularly puckered and cicatrised with some ulceration of the surface; the ileo-cæcal valve was cicatricial, hardly admitting the tip of the forefinger. Under these circumstances, it was considered best to excise the affected area, so the small intestine was cut across about an inch from the ileo-cæcal valve, and the ascending colon divided above the thickened area. The end of the colon was closed with a double row of continuous silk sutures, and the ileum afterwards placed into an opening made in the principal longitudinal muscular band of the large bowel about an inch and a half above the closed end. The small bowel was secured in position by means of continuous stitches, the first including all the coats of the gut. The parts were cleansed and replaced in the abdominal cavity, the abdominal wound being sutured in three layers. Mr. Battle said that tubercle of the appendix, as was proved in this case—not only by the examination of the specimen after removal, but in the theatre and in the clinical laboratory—is a rare condition, one seldom diagnosed before operation. The symptoms, he pointed out, are rather misleading, the diagnosis usually made being that of ordinary appendicitis, and it was probable that in this instance there would have been a failure in this respect had there not been the history of removal of tuberculous glands. The operation of excision, he remarked, might appear to have been somewhat

severe, but considering the extent of the disease and the contraction at the ileo-cæcal valve, nothing less would have afforded a prospect of ultimate cure. An attempt to remove the rigid friable appendix, he thought, would have made a large hole in the diseased cæcum, one which it would have been very difficult to close successfully. The walls of the cæcum were so hard and stiff that the sutures would have most certainly cut their way out, whilst any further diminution in size of the cæcum thus altered by disease would have increased the difficulty in the passage of the faecal contents.

The patient made a good recovery, the wound healing by first intention.

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The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, MAY 31, 1905.

THE GENERAL MEDICAL COUNCIL.

THE opening last week of the Spring Session of the General Medical Council has been distinguished by the advent of the new president, Dr. Donald MacAlister. His first appearance in that capacity has been marked by an address, the tone of which is distinctly that of happy augury. He announced that by means of certain common-sense budget proposals there is a prospect of placing the affairs of the Council upon a sound financial basis. It is to be hoped that henceforth, under his guidance, the governing body of the profession will recognise the elementary duty of living within their means and of adjusting the balance of income and expenditure in a satisfactory way without further taxing qualified men and medical students. Among other matters touched upon by Professor MacAlister, however, was one that may possibly have a most vital influence upon the future interests of the medical profession in the United Kingdom. He was enabled to relate a series of legal and governmental proceedings in relation to medical and dental companies, and the abuses to which they give rise. The question was originally raised in Ireland in connection with registered trading companies practising as dentists. It has

now extended to a far wider field, and has gradually involved the recognition of an underlying principle of the utmost importance to medical men. In other words, if it be illegal for a registered company to practise dentistry, which is a branch of legitimate medical practice, it follows that it is equally illegal for similar trading corporations to practise medicine itself. The enforcement of the larger proposition would strike a mortal blow at an enormous mass of irregular medical practice, the extent of which can be to some extent gauged by the costly advertisements which lie everywhere in wait for the unwary. None but a lawyer would attempt to defend the legality of such practice in face of the fixed principle and tendency of the Medical Acts, the whole reason for which is the protection of the citizen against unqualified medical practice. By the imperfect and haphazard nature of this special legislation, however, a host of irregular practitioners are permitted to prey upon the public on the one hand, and, on the other, to defraud the medical profession of the practice to which it is entitled by legal and moral no less than by traditional right. If permission to practise medicine be denied to registered companies, it can hardly be granted to unqualified private individuals. So far as the General Medical Council is concerned, the Lord President of the Privy Council, after some correspondence with the Council, has announced that the Attorney-General of England would be prepared to prosecute at the instance of a proper relator. The first great starting-point in the present series of proceedings was the judgment of Chief Baron Palles, to the effect that a dental company whose proposed title was such as to mislead the public into supposing that its business was carried on by qualified persons might lawfully be refused registration under the Joint Stock Companies Acts. The question then naturally arose whether a company already registered, whose title was open to the same objection, might lawfully remain upon the register. To that query a judgment in the negative has been given in the High Court of Justice of Ireland by the Master of the Rolls in the case of the Attorney-General *versus* Appleton and others. That most important decision was recently made the subject of questions in the House of Commons by Sir J. Batty Tuke, who deserves the gratitude of the whole medical profession for thus pressing the matter on the attention of Government. The foregoing facts were laid by Dr. MacAlister before the Lord President of the Privy Council, with the view of ascertaining what steps could be taken to procure a similar declaration of the law in Great Britain. The reply, as already intimated, shows that the English Attorney-General is ready to act in the matter as soon as he is supplied by an authoritative spur to action. This result is most satisfactory, and does more to retrieve the reputation of the General Medical Council than any single previous act with which we are acquainted. Instead of the selfish, helpless, impotent and generally

feeble attitude which the medical profession has learned to associate with the Council, we are here suddenly confronted with a bold move, striking at the root of things and making use of the great political organisation of administrative Government, of which the General Medical Council has hitherto formed an apparently dead and withered branch. After this welcome action it may not be perhaps too much to hope for a reformation of the medical Parliament under the leadership of Professor MacAlister, so that in future the General Council may regard the interests of medical men rather than of medical corporations, that it may conform to the principles of representative election, and that it may advance the legislative consolidation and protection of the rights of legitimate medical practice.

AERIAL CONVECTION OF DISEASE.

THE facts relating to the method of spread of the infectious diseases are gradually becoming more and more definitely known, and in proportion as they are known means of prevention become at once more exact and more hopeful of success. To recognise *bacillus typhosus*, its mode of exit from the body in the urine and fæces, and its entrance into the bodies of other persons by means of contaminated water, suggests immediately the lines on which preventive measures should be framed; namely, by the disinfection of the excreta of typhoid patients and by the safeguarding of the water-supply of the healthy. By the universal adoption of these means it ought to be humanly possible to eradicate typhoid fever from a community unless there be still other agencies whose existence has not yet been established. If, for instance, flies could be shown to be actual carriers of infection from fæces to food, the discovery would suggest its own remedy. But hitherto the diseases that have proved, as a class, the most difficult to deal with from the point of view of prevention are those in which the infection is acquired by inhalation. Such, for example, are measles, whooping-cough, pulmonary tuberculosis, and probably small-pox and chicken-pox. Although the bacteriology of none of these maladies is certainly ascertained as yet, except in the case of tuberculosis, there would seem to be little room for doubt that the main channel of entrance of the infection is through the respiratory tract. It would seem then necessarily to follow that they are acquired through aerial infection, and that it is to measures directed to freeing the air from the infecting particles that regard must be paid if prevention is to be accomplished. One can, then, only be surprised that so little satisfactory work has been accomplished in connection with aerial infection, for it would seem to be intimately associated with the solution of many of the gravest problems of disease-prevention. The usual methods for the bacteriological examination of air, Frankland's, Petri's, Hesse's, and Sedgwick and Rucker's, have all hitherto failed to demonstrate pathogenic or-

ganisms in the air in anything like the quantity in which they must exist, and the suspicion arises in the mind that there must be some fault somewhere in the technique of the procedures. Doubtless myriads of pathogenic bacteria are killed by dessication and by the action of sunlight, but, on the other hand, many must survive, if the evidences of microbial action in the air passages of man are not to be disregarded. In a recent paper read before the Epidemiological Society, Dr. Buchanan, of the Local Government Board, summed up the evidence in favour of small-pox hospitals acting as foci whence variola was distributed by aerial convection to neighbouring dwellings, and this evidence is difficult to discount. Since 1886, when Mr. Power showed, in the case of the Fulham Small-pox Hospital, that by drawing circles with varying radii round the hospital, the incidence of the disease became milder as the distance from the hospital increased, the Local Government Board have favoured the theory of aerial convection and acted on it in the cases of small-pox hospitals, though many medical officers of health have repudiated the idea. That Dr. Buchanan's paper will effect a conversion of the majority is, perhaps, too much to expect, but the onus of finding a sufficient interpretation of his striking figures will lie with them. For instance, it would seem impossible not to believe that aerial convection was the agency which produced the succession of cases of small-pox that occurred in the Essex towns lying opposite the Small-pox Hospital Ships in the Thames during the outbreak in London 1901-2, and still more so when small-pox broke out in vessels that moored in the same reach as the hospital ships, and came into no direct or indirect contact with them. Still more cogent was the evidence supplied from Liverpool from the experience of the 1902 epidemic. In that city there were two old hospitals and one new one, the latter situated outside the urban area. Before the new one was completed the two old hospitals were used for the reception of patients, and in the case of both these hospitals there was a severe invasion of the neighbouring houses, those closest to the hospitals suffering the most markedly. When the new hospital was opened and the old ones were closed the incidence of small-pox in their vicinity fell to the normal of the other districts of Liverpool. While the micro-organism of small-pox is still undetermined, or, at least, in dispute, it is not possible to determine the important question of its transmission by the air, and even if the organism itself were indisputably established, it would seem that more fruitful methods of demonstrating it in the air than at present exist would be necessary. The germ itself would seem to be capable of resisting dessication to a considerable degree, as it is hardly possible to regard it as borne for long distances in a state of moisture. The most recent experiments on the convection of the organisms of the mouth through the air of rooms and cities—namely, those described by Dr. Gordon in the Local

Government Board Report, 1902-3, showed that organisms conveyed in the saliva-droplets that are sprayed from the mouth in loud speaking can be carried as far as forty feet in a room, but that in the open air these organisms are rare and difficult to recover. However poor is the tangible evidence of the dissemination of infecting organisms through the air—and at present it is very poor—the presumptive evidence is too great to be neglected. It is greatly to be hoped that fresh means of investigating these problems may be forthcoming, for it may be said without exaggeration that if aerial influences in the dissemination of disease could be eliminated, more than half the present mortality from infectious diseases would be obviated.

Notes on Current Topics.

The Registration of Bogus Dentists.

WE are glad to learn from information laid before the General Medical Council at its recent meeting that it has been at last made clear to the excessively cautious English Law Officers, and to the equally cautious English Branch of the British Dental Association, that it is possible to take effective action to check, not alone the registration of additional companies for the practice of dentistry, but also to cause the removal of those already registered from the list of joint-stock companies. In the past, as our readers may remember, neither the Law Officers nor the Association could be induced to act, although the latter body possessed ample funds to institute a test case. It remained then for its poorer but more active brother, the Irish branch of the Association, to put its hands deeply into its pockets and to demonstrate to all concerned that bogus companies can be driven out of existence. As soon as this was done in Ireland, the English branch took heart, and through the General Medical Council have obtained a very satisfactory answer from the Lords of the Privy Council, that "if a case of a like nature to that ruled upon in Ireland by the Master of the Rolls arises in England, it will be open to the English branch of the British Dental Association to move in the matter as apparently the branch in Ireland has done." This declaration, though at first sight it appears merely to state a self-evident fact, is important, as it will be necessary for the Attorney-General to act in the matter, and the letter from the Privy Council apparently affords a guarantee that he will so act. In our leader columns we have congratulated the English Council on its belated determination to take active steps in this important matter, but we should congratulate it more heartily had it shown the way, or even associated itself with the Irish branch when its aid was asked. The Irish branch of the Association has shown the way to other bodies also, and we trust that in the near future its lead will be followed. There are at present several instances of companies in Ireland for the bogus practice of medicine and surgery, and we trust that

so soon as the reform of the Irish Medical Association is complete, it will turn its attention to their eradication. By so doing, it will enhance its reputation and attract new members, and in that way render unnecessary the schemes and plots which have recently marred its policy.

The Future Issue of the "Directory" of the Irish Medical Association.

THE June number of the journal of the Irish Medical Association has been issued before its time in order that the report of the Re-organisation Committee may be in the hands of the members before the general meeting that is to be held next week. The journal also contains the Annual Report, which is to be laid before the meeting. Time forbids us from commenting on the report at length, but one point of importance deserves notice. The Council, in the report, lays before the meeting an account of the origin and mode of creation of the now notorious "Directory," in which report it is inclined to throw the blame for its discreditable nature on Messrs. Churchill, of London, the publishers of the "Medical Directory," because they did not allow the Council to copy all details from their work. The report states that, in consequence of this, it was impossible to go to the same trouble and expense in the case of non-members as in the case of members, that is to say, that it was impossible to ascertain their qualifications, which, in the case of the non-members, were obtained from the Medical Register. This is a singularly lame excuse, as the qualifications of the one class are as obvious as the qualifications of the other in the pages of the latter work. Moreover, assuming the excuse to be good the very fact that such a course was followed must have immediately shown its compiler that it was false to describe the "Directory" as "reliable and accurate." The report further states that "now, however, it has been decided that any medical practitioner—member or non-member—who before September 1st sends in the form attached to his 'Directory,' shall have the qualifications, &c., written thereon, inserted after his name in the next issue." We refuse to believe that the Council of the Association deliberately sanctioned such a paragraph. An undertaking was given to the Committee of Council that in future a circular should be sent to every medical man in Ireland asking for his qualifications, &c., for use in a further issue, and now we are told that if medical men send in a form attached to the present "Directory," their qualifications, &c., will be published. It is unnecessary to point out to the formulator of this very ingenious arrangement, first, that non-members have no prospect of seeing the notice asking that the form in question shall be returned, seeing that they do not receive the journal of the Association; and secondly, that most non-members will have destroyed in disgust long before this the so-called "Directory" which was sent gratis to them. We trust that at its coming meeting the Association will determinedly face the

responsibilities which have been thrust upon it by the issue of the "Directory," will definitely dissociate itself from the "Directory" in its present form, and that if the latter is ever again to appear, will see that it so appears as to bring not disgrace, but credit upon the Association. It is a matter on which there can be no further hedging, if the Association is to resume the place which it should occupy in the medical world.

Cerebro-Spinal Meningitis.

THE reports of cerebro-spinal meningitis from Germany show that the disease has gained a considerable foothold in that country. According to a Reuter telegram, which quotes the statement of the *Norddeutsche Allgemeine Zeitung*, since April 30th 1,935 cases and 994 deaths have occurred in Prussia; 1,814 cases and 932 deaths in Silesia; and 1,955 cases with 1,002 deaths in the district of Oppeln. Recently the malady appeared in the town and district of Kattowitz, forty-six people being attacked, thirty-seven of these fatally. Moreover, several isolated cases have been met with in Berlin, some of which have resulted in death. Figures like these, which have every indication of being drawn from official sources, cannot be regarded without uneasiness. If cerebro-spinal meningitis can spread so widely and so virulently in the warm weather, it is not improbable that the winter will see an even greater incidence among the population, an incidence which may easily assume epidemic proportions. Fortunately free as this country has been, several more cases have occurred, mostly at Irthlingborough in Northamptonshire, where twelve individuals have been attacked and four deaths have resulted. The Local Government Board are on the alert, and have sent an inspector to Irthlingborough to advise and report, and it may be confidently anticipated that preventive measures of a vigorous kind will be employed. But with a disease of which so little is known as with cerebro-spinal meningitis, it is not possible to do more than to use the ordinary methods of disinfection and isolation. The situation, therefore, although not calling for alarm, is not free from elements of anxiety.

Pure Beer!

WHAT is beer? The question was brought prominently before the public a few years ago by the arsenical beer scare at Manchester. A logician would divide beverages into beer and not-beer. His difficulty would begin with the definition of beer. It is likely that no article of popular consumption is more widely and systematically adulterated than the traditional drink of an Englishman. The list of adulterants used is simply appalling. In the House of Commons last week the Chancellor of the Exchequer stated that as regards the two years ended April 30, 1905, a caution had been issued by the Board of Inland Revenue as to the use of the following materials:—Heading powders, &c., Minoka juice,

Dublin stout heading, optacreme, clarifoam, cortex quillaia pulvis. Preservatives, &c.—Alginol, universal preservative tablets, phylax, salicylic acid, kalia meta sulphite, antacid neutralisers, gypsum, magnesia sulphate. Hop substitutes, &c.—Optanin, Bradley's hop supplement, Estcourt's hop supplement. In the following cases the use of the article was objected to by the Inland Revenue:—Flavouring Essences—Malt, yeast foods, glucose, invert sugar, &c., containing arsenic; peptomides, containing arsenic and copper stoutine, Baines's combined heading and beer preservative, optacreme, ecumin, moussine, clarifoam, heading powders and liquids containing quillaia extract; saccharin, sucramine, and other compounds containing saccharin. Temperance reformers will doubtless chuckle over this inventory.

What is Professional Negligence?

A CASE of considerable importance to the medical profession has recently been tried at the Liverpool Assizes. It appears that the porter at a golf club was attended for a skin trouble by a medical man at West Kirby, who diagnosed syphilis. This opinion was conveyed by the patient himself to the club secretary, with the result that the man lost his situation. As a matter of fact the malady was not syphilis, but simply an attack of scabies. The real nature of the disease appears not to have been disputed at the trial. The main point at issue was that of negligence, whether by the exercise of reasonable care and skill the error in diagnosis, with all its serious results, would have been avoidable. The judge held that the plaintiff's discharge was the direct consequence of the error, in spite of the fact that the plaintiff himself made the communication to the club secretary. The claim for £71 10s. was allowed with costs. Notice of appeal has been lodged, so the case cannot be discussed further for the present.

Pathological Material by Post.

IT is natural that the mind of the man-in-the-street should be agitated by the knowledge that, so to speak, concentrated specimens of all kinds of deadly disease are passing daily through the post-office. Equally natural is it that the Postmaster-General should insist upon special precautions being taken to secure safe transit of pathological material. The scientific examination and report upon such specimens has become part and parcel of the routine of practice, both general and special. This new branch of medical investigation, beyond the shadow of a doubt, has conferred an enormous boon upon the community by way of the rapid detection of diseases that may be disastrously rapid or infectious. That the post-office risk is slight may be gathered from the statement of Dr. Hutchinson last week in the House of Commons. By way of comment on an answer from Lord Stanley, the Postmaster-General, he observed that something like a million of these specimens went through the post last year with-

out a specially-marked envelope and compulsory registration, and yet no accident took place. Lord Stanley, however, declined to permit the proposed new rules as to registration and distinguishing wrapper to be relaxed. Nor did he give a more encouraging reply to the suggestion of Dr. Hutchinson that a great amount of inconvenience and danger was caused to everyone by the closing of the post-offices from eight o'clock on Saturday night to eight on Monday morning.

Anatomy in America.

THE Wistar Institute in Philadelphia, founded some years ago to house the old Wistar and Horner Museum, and to further the study of anatomy, has taken an interesting step in inviting to a conference ten of the leading American anatomists. The primary object of the conference was to discuss the best methods by which the Institute might be made of service in the development of the science of anatomy as a whole, and the members present threw themselves zealously into the work, with the result that a very complete system has been sketched for the future conduct of the Institute. There is to be a permanent advisory board composed of anatomists from various parts of America, by whose aid the scope of the Institute will be much widened. The Institute itself is to form a Central Institute for neurologic, anatomic, and embryonic research along lines to be decided by the advisory board. In addition, the anatomists through the country hope to help the museum by presents of specimens which, together with the material already in hand, should make it take a first place among museums of the New World. It is gratifying to find anatomists all over the States co-operating in this way to further the science whose devotees they are.

The Application of the Widal Test.

THE agglutination test for specific diseases, particularly in the case of typhoid fever, has taken so firm a position as a diagnostic measure of the first importance that there can be no fear of any loss of confidence in it taking place. Nevertheless, it is well that certain limitations and fallacies occurring in its application should be borne in mind, so that misunderstanding and disappointment may be avoided. It is often forgotten, for instance, that strains of typhoid bacilli tend to undergo certain changes in the artificial life of the culture tube, which may interfere with their reaction to an agglutinating serum. Thus, it has been noticed that during the first six months of laboratory life typhoid strains are lacking to a certain extent in agglutinating power, while after that period the power remains fairly constant, if care be taken to make frequent sub-cultures. In the application of the agglutination test, very marked difference of results may occur with the same serum if the test be performed at different temperatures. Thus Schellen has noted the curious phenomenon of complete agglutination occurring at low dilution in fifteen minutes at room

temperature, while the control preparation in the incubator at blood heat exhibited a lesser degree of agglutination after two hours. Ignorance of this possibility easily leads to a wrong judgment of results, since it is usual to leave the preparation in the incubator while waiting for the reaction. Though most observers are on the watch against pseudo-clumping, yet it is a phenomenon not sufficiently studied. A sudden change of temperature frequently causes it, Klotz having noticed its occurrence on the mere change from the warm incubator to a cool laboratory. Every practical worker has probably met and noted particular difficulties, and it is important that the attention of his fellows should be drawn to them, so that fallacy may be avoided and the full use made of an important aid to diagnosis.

Air Embolism.

It is a little over a hundred years since it was first pointed out that serious consequences are liable to follow the admission of air to the venous channels. There is little doubt that many of the cases reported as air embolism, however, are not truly of that nature, and the modern knowledge of the properties of the *bacillus aerogenes capsulatus* explains the origin of many of the supposed cases. Nevertheless, it is quite true that the entrance of air into the veins is always an occurrence of serious import, and in operations at the base of the neck this danger has to be borne in mind. The accident, however, does not happen at all frequently, in spite of the comparative frequency of wounds of the great vessels. This, indeed, constitutes one of the puzzles of the phenomenon, as the conditions which govern its occurrence have never been made clear. The clinical series which follow is better known. General unconsciousness occurs at once, the pulse becomes feeble, and death usually follows in a few minutes. Churning movements are discernible over the right side of the heart while life lasts, and the chambers on that side are found after death full of froth and blood. The great puzzle about the whole condition, however, is to discover why death results. The theories put forward are very various. Some have held that the heart is unable to contract on a mixture of blood and air, and that death results from cardiac paralysis. Others put forward the view that death is the result of the blockage of cerebral vessels by air emboli, and others again regard it as due to a similar condition of the pulmonary vessels. Whatever theory holds—and none can at present be regarded as conclusive—every case that occurs should receive very careful clinical and pathological investigation.

Christian Science, Poulitices and Pneumonia.

THE cult of the Christian Scientists appears to be dragging on a precarious existence in the United Kingdom. That fact is somewhat noteworthy when we reflect how steadily their ranks have been thinned by the remorseless hand of death. To

some extent it may be conjectured that the mysterious workings of Providence are bent upon exterminating these foolish folk by permitting them to join the grotesque army of Christian Science. If a man wishes to end his existence, it does not after all, much concern the rest of the world. It is quite another matter, however, when he plays fast and loose with the lives of other persons. A man possessed of this form of moral dementia designated Christian Science is unfitted to be the responsible guardian and custodian of children. Last week an inquest was held at Twickenham, on the body of a child who died of pneumonia. The father, being one of these so-called scientists, elected to have his child prayed over by a faith-healer, Miss Wilkins, at a guinea a week, instead of trusting to a qualified medical man. The soundness of the father's judgment may be gauged by the fact that although he did not consider himself justified in inflicting pain upon the child by applying poultices, he used hot rice water without scruple. It is useless to argue with a man in that kind of intellectual tangle, while the censure of a coroner's court appears to be looked upon by these mentally ill-balanced persons as a badge of personal honour.

The Potter's Thumb.

DETRACTORS and sensation-lovers are seldom tired of railing at the materialism, as they are pleased to call it, of medical men. What their argument amounts to, when stated in plain English, is that medical men have a habit, ingrained in them by their study and practice, of working to natural facts before being led away by fanciful theories and artistic extravagances. This respect for the laws of Nature is apt to clash awkwardly with the artificial absurdities of leaders of fashion and their parasitic satellites; consequently, doctors are called materialists and other hard names, of the meaning of which often their users have very little apprehension. Moreover, the doctor, in taking his stand between his patients and the freaks of fashion, incidentally finds himself on the side of that true artistic ideal which aims at the expression of beauty, rather than on that which betrays morbid imaginings of decadent sentimentalists. We are led to these remarks by perusing, in a fashionable paper, the statement that "this year's figure (for ladies) is not the same as the figure of last year, and the figure of next year will not be the same as the figure of this year." If we had only read the first part of the sentence we should have been profoundly grateful, for it is hardly possible to conceive of a more grotesque travesty of woman's natural form than was displayed by the "figure of last year." Any illusion that the change meant a return to a healthier and more natural figure is however dissipated by the statement that "next year's figure will not be the same as the figure of this year." We would like to take the creators of these "figures" and their unhappy victims through the case-books of a few medical men, and show

them the harm that is wrought by their ignorant meddlesomeness. The human figure that was once pronounced "very good," and which artists and anatomists have never yet found fault with, seems to have become the prey of the thumb of a tribe of selfish and Philistine potters.

Greenland for Consumptives.

THE different treatments for consumption that have been recommended during the last century constitute one of the most variegated pages in medical history. If a chair for the study of the latter subject be ever founded, it would be an interesting task for the professor to review and classify the various plans that have been adopted or advocated. During the last twenty years the climatic factor, in one form or another, has been at the base of most orthodox prescriptions, though the climates recommended have varied in every possible degree of altitude and position, from Davos Platz to the Egyptian desert. We heard recently of the Sahara being considered as a health-resort, and now we find the claims of the Arctic regions pressed forward. A Dr. Sohon, of America, having found himself the subject of pulmonary tubercle, took a trip to Greenland with Commander Peary, and returned home sound in wind and limb. Since then he has made another similar journey, and now he is so much enamoured of the climate that an expedition is being fitted out from Washington with the object of sending a batch of consumptives for a cruise along the central coast of Greenland. The steamer *Havana* has been chartered, and is to sail from Halifax with its human freight on June 15th, and high hopes are entertained as to the benefits likely to accrue. We are not informed if the cases are being subjected to selection, but it would be wise for this to be done. If so, it may be safely affirmed that the bulk of the party will come home the better for their tour if anything like favourable weather be experienced. A judicious study of the natural history of a disease will enable any form of treatment not obviously injurious to hold the field—for a time. Within the limits the more strange and sensational the plan, the more likely is it to be favoured by the public.

Milk in Paper Bottles.

ONE of the most unsatisfactory of the many unsatisfactory features of the milk trade is the necessity for frequent handling in its transference from the cow to the consumer, each handling of course providing a fresh opportunity for contamination. The milk received into buckets by the milker, is put into churns; from the churns it is passed through a strainer at the dairy on its arrival in town, in many cases at least; thence it is transferred to cans, from cans to jugs, and from jugs to tumblers. Taking their cue from the arrangements long prevalent in France, the municipalities that supply sterilised milk for infants have put their milk into bottles, which have to be returned subsequently by the

purchaser. This prevents a certain amount of handling, but it is a clumsy and expensive method, and municipal "gouttes de lait" do not cover working expenses. A novel and interesting invention is reported from America, where the public conscience as regards its milk is far more awakened than in this country. This invention consists in the manufacture of bottles made out of paper prepared from spruce pulp, which can be hermetically sealed and are very inexpensive. The bottles are made in conical shape, and though light are very strong; it is stated that pressure of two hundred pounds can be borne by them without damage. Moreover, they can be sterilised. If the bottles are all that are claimed for them, their use in the dairy should be easily enforced by the customers insisting on receiving their milk in them. By this means many of the difficulties in the way of a pure milk supply should be capable of solution.

Surgery at Sea.

THOSE that go down to the sea in ships have opportunities of seeing medical practice under different and, as a rule, less favourable conditions than their land-lubbering brethren. There is, perhaps, no situation in which the resourcefulness and ingenuity of a doctor are more severely taxed than when a ship's surgeon is called upon to act in a grave emergency. It is obviously impossible for any vessel to provide the apparatus and assistance necessary for every contingency that may arise in practice, and the surgeon is not infrequently placed in the position of having to do the best he can with the instruments at his disposal, and the aid he can obtain from the crew or passengers. When to these difficulties is added the further handicap of bad weather, the position calls for the utmost readiness and skill. In spite of all these drawbacks information is often coming to hand of ships' surgeons and others carrying out emergency operations, but a case that is just reported as having taken place on the mail-boat *Solent* during a voyage from Barbadoes to Southampton is sufficiently uncommon to merit notice. One of the passengers, a corporal of the Worcester Regiment, was suffering from gastric ulcer, and his condition became so precarious that Dr. H. W. Bayly, of London, and a passenger came to the conclusion that only by operation could his life be saved. Stormy weather prevailed at the time, but the operation, the details of which are not mentioned in the report, was carried out successfully, and the patient was landed alive at Plymouth, and is now doing well. To attempt a grave abdominal operation under the conditions that prevailed exhibits no common degree of pluck on the part of the surgeon, and we congratulate Dr. Bayly heartily on the well-earned satisfaction that he must be feeling at the success of his undertaking.

MR. J. LYNN THOMAS, C.B., has been elected president of the Cardiff Medical Society for the ensuing season.

PERSONAL.

THE 37th annual dinner in aid of the French Hospital took place last Thursday, at the Hotel Cecil, under the presidency of M. Paul Cambon, the French Ambassador.

H.R.H. THE DUCHESS OF ALBANY has promised to attend a garden fete to be held at the Manor House, Stoke D'Abernon, Surrey, by kind permission of Mr. and Mrs. F. A. Phillips, on Saturday, June 17th, in aid of the funds of the Royal Waterloo Hospital for Children and Women.

SIR W. T. LEWIS has contributed £1,000 to endow a bed, to be named "The Lady Lewis Bed," at the new Seamen's Hospital, Cardiff.

PROFESSOR D. O. OTT has been ordered to join the acting Russian army for four months, to investigate the nature of medical organisation in the army.

DR. GADDES presided at the annual conference of the members of the British Dental Association, held last week at Southport.

PROFESSOR KOCH, who is now at Iringa, in the interior of Africa, will not return to the coast till the end of July, nor to Germany before the spring of 1906.

MR. CHARLES COTTON, M.R.C.S. (from Honorary Associate), and Major George Lane Mullins, M.D. have been appointed Knights of Grace of the Order of St. John of Jerusalem in England.

DR. A. D. GRIFFITHS, of Bridgend, has been presented with the sum of £70, subscribed to defray some of the legal expenses entailed on him by an action brought to resist attempted blackmail.

THE Romanes Lecture before the University of Oxford will be delivered by Edwin Ray Lankester, M.A., F.R.S., Director of the Natural History Museum, South Kensington, in the Sheldonian Theatre, on June 14th, subject—"Man and Nature."

THE 123rd Harveian Festival will be held in the hall of the Royal College of Physicians, on June 6th, at 6.30 p.m., when the President, Charles E. Underhill, M.B., F.R.C.S.E., will deliver the Harveian Oration on "Harvey as a Teacher."

Two of the Irish members of the General Medical Council took their seats at the recent meeting for the first time. Sir Thomas Myles took the place of Sir Charles Ball as representative of the Royal College of Surgeons, and Dr. Arthur Atcock took the place of the late Mr. C. R. C. Tichborne as representative of the Apothecaries' Hall of Ireland.

WE are informed that Dr. G. E. J. Greene, of Ferns, vice-president of the Irish Medical Association, has come forward as a candidate for the post of Direct Representative for Ireland on the General Medical Council. Dr. Greene has long been an energetic member of the Council of the Association. We think that both he and Dr. Mahon, of Ballinrobe—who is also a candidate—would do well to announce publicly their views regarding the publication known as the "Irish Medical Directory for 1905," and also regarding the policy advocated editorially in the journal of the Association for May.

DR. GEORGE OLIVER will lecture in the Physiological Laboratory, University of London, South Kensington, on Monday, June 5th at 5 p.m., on "Hæmomanometry in Man." Admission to the lecture is free. Students of any school of the University and medical men will be admitted on presentation of their cards.

DR. T. J. FORDYCE MESSER, of Helensburgh, on the occasion of his retirement from practice, has been

presented with a public testimonial, consisting of an illuminated address, a purse of 200 sovereigns, and gold bracelets for his wife and daughter and, from the Helensburgh Lodge of Oddfellows, a purse of sovereigns.

THE Conway Town Council last week made a handsome presentation to Dr. M. J. Morgan, on the occasion of his return from his wedding tour.

THE Home Secretary has informed Mr. J. G. Weir, M.P., that during the past ten years twenty names have been struck off the *Medical Register* for infamous conduct in a professional respect, and twelve names have been restored thereto. During the same period six names have been struck off the *Dentists' Register* for infamous or disgraceful conduct in a professional respect, and one name has been restored.

DR. HOWARD KELLY, of Baltimore, will deliver an address before the British Gynaecological Society on "Tuberculosis of the Urinary Tract in Females," on Thursday, June 8th. A *Conversazione* will be held after the meeting.

THE GENERAL COUNCIL OF MEDICAL EDUCATION AND REGISTRATION.

DR. MACALISTER, President, in the Chair.

TUESDAY, MAY 23RD.

THE eighty-first session of the Council was commenced to-day, Dr. DONALD MACALISTER, the President, being in the chair.

NEW MEMBERS.

Sir Thomas Myles, appointed by the Royal College of Surgeons in Ireland as a member of the Council *vice* Sir Charles Ball, was introduced by Sir William Thomson, and took his seat. Dr. Arthur Atock, appointed by the Apothecaries' Hall of Ireland as a member of the Council to succeed the late Mr. C. R. C. Tichborne, was introduced by Dr. Little and took his seat.

THE PRESIDENT'S ADDRESS.

After reference to the losses sustained by the Council through deaths and resignations, he briefly alluded to certain matters which had occurred during the recess. In accordance with the resolution of Council of November 29th, he (the President) addressed a communication to the Lord President of the Privy Council on the subject of medical and dental companies and of the abuses to which they give rise. The Lord President, in reply, asked for detailed evidence in support of these representations. This evidence the Registrar, with the help of members of the Companies Bill Committee, was enabled to collect and to forward for the Lord President's consideration. It would be remembered that, according to the judgment of Chief Baron Palles, a dental company whose proposed title is such as to mislead the public into supposing that its business is carried on by qualified persons may lawfully be refused registration under the Joint Stock Companies Acts. The question arose whether a company already registered, whose title was open to the same objection, might lawfully remain upon the register. A judgment in the negative has now been given in the High Court of Justice in Ireland by the Master of the Rolls in the case of the Attorney-General *versus* Appleton and others. This important decision was made the subject of questions in Parliament by Sir John Tuke who had been most active in pressing the matter on the attention of the Government; and he (the President) communicated a full report of the case, courteously furnished by the British Dental Association, to the Lord President. The purpose of these questions and communications was to ascertain what steps could be taken to procure a similar declaration of the law in Great Britain. The replies would be laid before them. As the result of a confidential communication from the Army Council this Council

on November 22nd, 1904, appointed a committee to inquire into the operation of the Anatomy Acts and their effect on the teaching of anatomy and practical surgery in Great Britain. A further communication from the War Office was received in March, from which it is apparent that the inquiry then directed is of pressing importance. To facilitate the work of the committee he had opened communications with a number of the authorities concerned, and the information thereby obtained, much of which is of a confidential character, will require careful consideration.

The Council would also learn with satisfaction that the accounts for the year 1904 are more favourable than those for any year since 1895. At the end of 1903 the deficit was some £2,165; at the end of 1904 it was only £218, or about one-tenth as great. The Finance Committee would report on the items which have contributed to this substantial improvement, but it was noteworthy that the result is attributable not to any increase of ordinary income, but to greater economy of expenditure. Whether this degree of economy could be maintained in future years without impairing the Council's efficiency it was difficult to forecast. But though he might be charged with incurable optimism regarding the Council's finances, he still thought that in ordinary years equilibrium between income and expenditure was possible of attainment, even without the aid of fresh legislation, in which belief he was strengthened by the opinion of the Finance Committee. Dr. Mackay's suggestion—that the fees for the restoration of lapsed names to the registers and for the registration of higher titles should be slightly raised—had proved to be fruitful, for it had added over £400 to the receipts of the year. The higher fee, so far as it represents a fine for negligence, would incidentally tend to keep the registers more correct. The fee for recording additional qualifications being, as it were, a small tax on new dignities, is paid with comparative complacency by the newly dignified. Dr. Mackay's proposal was thus abundantly justified and the Chancellor of the Exchequer in search of fresh sources of revenue might well take counsel with him.

The suggestion had been made from an important quarter that one of the services gratuitously performed by the Council might be made self-supporting in a similar way. He referred to the maintenance of the Students' Registers. The General Registrar, with the help of the branch registrars, had ascertained that the ordinary expenditure for printing, postage, salaries, and time occupied in committees and councils over its details cost about £400 a year. Against this outlay the only receipts are some £20 a year from fees for late or exceptional registration. If a fee, say, of 5s. were charged for the certificate of registration in ordinary as well as exceptional cases the actual cost would just be covered, and the Council's funds would be relieved to a corresponding extent. It is represented that for such a step no new legislation would be required, that the Students' Registers might remain on their present "voluntary" basis, that the trifling fee would be readily paid and easily collected, and that the future action of the Council and of the licensing bodies in regard to students' registration would in no wise be prejudiced. These representations he offered for consideration; the Council might be well advised to make the experiment.

He then announced that the reports of the supplementary inspections of the Universities of Oxford and London would be brought before the Council by the Examination Committee. In his opinion they were highly satisfactory. After referring to the Pharmacopœia Committee, the President announced that the penal cases would be heard on Wednesday and Thursday and concluded his address by assuring the chairmen of committees and other members of the Council of his willingness to assist them in every possible manner.

On the motion of Dr. WINDLE, the President was thanked for his address, which was ordered to be printed in the minutes.

THE BUSINESS COMMITTEE.

Dr. NORMAN MOORE moved that the following members should compose the Business Committee:—The President, Dr. Windle, Dr. Bruce, Sir Christopher Nixon, and Mr. Young.

Sir JOHN MOORE seconded the motion, which was agreed to.

YEARLY EXAMINATION TABLES.

On the motion of Dr. WINDLE, seconded by Dr. NORMAN MOORE, the following yearly tables for 1904 were received and entered on the minutes:—

(a) I. and II. Tables showing results of professional medical examinations during 1904; (b) table showing results of professional examinations for qualifications in sanitary science, public health, or State medicine during 1904; (c) table showing results of professional dental examinations during 1904; (d) table showing results of preliminary examinations during 1904; (e) answers sent by the medical authorities as to the exemptions granted by them in any part of their examinations during the year 1904; (f) table showing results of competition held on November 14th, 1904, for commissions in the medical staff of the Royal Navy; (g) table showing results of competition held in January, 1905, for commissions in the Army Medical Service; and (h) and (i) tables showing results of competition held in August, 1904, and January, 1905, for commissions in the Indian Medical Service.

The thanks of the Council were then voted to be conveyed to the Director-General of the Medical Department of the Royal Navy, 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.

The Council next sat *in camera*; at its conclusion the PRESIDENT intimated that the Council had resolved to direct the Registrar to restore to the Medical Register the name of Samuel B. Shekleton.

AMENDMENT OF THE COMPANIES ACTS.

The PRESIDENT said he had now to lay before the Council a statement of the steps taken since November, 1904, in regard to the suggested amendment of the Companies Acts by himself and also by Sir John Batty Tuke, to whom they owed a great deal for having pressed these matters on the attention of the Government. The latest expression of opinion by the Privy Council was contained in the following letter:—

Privy Council Office, May 19th, 1905.

SIR,—Referring to your letter of 17th inst., on the subject of the registration of medical and dental companies and inquiring whether in view of the decision of the Master of the Rolls in Ireland in the case of the Attorney-General for Ireland *v.* Appleton and others, the Attorney-General for England would take similar proceedings in the courts here at the instance of a proper relator, I am directed by the Lords of the Council to state for the information of the General Medical Council that it appears to their Lordships that if a case of a like nature to that above cited arose in this country it would be open to the English branch of the British Dental Association to move in the matter, as apparently the branch in Ireland has done.

I am, &c.,

The Registrar &c. (Signed) A. W. FITZ ROY.

The process should be that through the Attorney-General, who must consent to act, an injunction should be asked for to prevent a company already registered with a title which had been misleading from remaining on the register of joint-stock companies. If one good case were brought up and the decision were the same as that given in Ireland that would mean that a number of companies with misleading titles in connection with medical and dental practice might be removed from the privileges of registered joint-stock companies. The suggestion was made that the British Dental Association should take up the matter. They were in a position, no doubt, to inquire into the circumstances of a clear case and present it in a proper form and in proper course. He moved

that the documents in connection with the matter be placed before the Companies Bill Committee to be considered.

Mr. TOMES, in seconding the motion, said that the Council was deeply indebted to the President for bringing about this result.

The motion was agreed to.

It was agreed to enter the report in the minutes of the day.

REQUEST FOR CHANGE OF DESIGNATION.

The Council considered the report of the Executive Committee in regard to the petition from 767 Licentiate of the Apothecaries' Society of London requesting an alteration in the Medical Register of the designation therein given to the qualification granted by the Society.

The report was ordered to be entered on the minutes.

The PRESIDENT said the prayer of the petition was as follows:—

Your petitioners therefore humbly pray that the General Council will forthwith order that, in respect of all persons who have passed or shall pass the qualifying examination of the Society conducted in manner prescribed by the Medical Act, 1886, and have received or shall receive the diploma of the Society, the qualification entered or to be entered in the Medical Register shall be changed from "Licentiate of the Society of Apothecaries" to "Licentiate in Medicine, Surgery, and Midwifery of the Society of Apothecaries," or such abbreviation thereof or other title as shall indicate that the persons holding the said qualification are legally qualified to practise in medicine, surgery, and midwifery.

He would direct the attention of the Council to the Medical Act of 1859, which governed this matter. It described the qualifications that were to be registered. After consideration of all those points the committee had no option but to come to the conclusion that without a change on the schedule of the Acts, which would require fresh legislation, the Registrar would not be justified in changing the designation of the Licentiates of the Society of Apothecaries.

Sir Thomas Myles said that apparently the Council had no power to alter the title, but he would like to know whether they might not suggest to those gentlemen how they were to get the alteration which they desired.

Sir Christopher Nixon submitted that the application for the changes which the Licentiates desired should come from the body itself. They had no right to interfere with the status or title of a body simply on the application of the Licentiates.

Dr. NORMAN MOORE said that he took an entirely different view. There had been prevalent in their profession an unfortunate desire, which he thought ought to be discouraged, to claim titles which had not been earned. They constantly heard that people who passed a certain examination were quite as good as those who studied at the University and who had the degree of doctor. This was a degrading tendency, against which the Council should set its face. The Society of Apothecaries of London had an honourable history, and if he were a Licentiate he should be proud of the title, and not anxious to assume another.

The President remarked that the petitioners asked a definite thing, and it was wise on the part of the Council to confine itself to a definite answer. The petitioners do not ask the Council to help them to obtain fresh legislation or to promote a Bill in Parliament. The finding of the committee was a precise answer to a well-formulated and clear question. The Council placed on the certificate of registration the statement that the qualification was a complete qualification for medicine, surgery, and midwifery, and on the first page of the Register there was a statement to the same effect. Mr. Muir Mackenzie advised the committee that that was the utmost extent to which their legal powers enabled them to go. It showed that the Council was anxious to make it clear to the public that those gentlemen were fully qualified.

The motion was agreed to and the report approved. After reading communications on "Medical Unions" and "Medical Certificates," the Council proceeded to the discussion of

DENTAL BUSINESS.

The Executive Committee presented the following report on the dental business transacted since the last meeting of the Council:—

(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: Charles Griffith, William Quantrell, Henry Schofield, and Alfred H. Thomas.

(2) Copies of the following Colonial Acts relating to the practice of dentistry were received from the Colonial Office and referred by the Executive Committee to the Dental Education and Examination Committee for its information: "The Dentists Act, 1904," of New Zealand; "The Dentists Act Amendment Act, 1904," of South Australia.

(3) The President reported as to the action that had been taken by him since the last session of the General Council in regard to the subject of the registration of medical and dental companies, and called attention to a recent judgment in the Irish courts, directing the removal of a dental company from the list of registered companies.

Sir John Batty Tuke read correspondence which had passed between himself and various Government departments and the chairman of a departmental committee of the Board of Trade on the operation of the Companies Acts.

It was resolved: That these additional documents be referred to the Companies Bill Committee of the Council for its information.

(4) The committee considered a communication from the Incorporated Society of Extractors and Adaptors of Teeth, Limited, forwarded under the impression that the Council was, in conjunction with the British Medical and Dental Associations, promoting a Bill for the amendment of the Medical Acts, requesting that a deputation might be received by the Medical Council to discuss the terms upon which provision should be made in any future legislation—to be obtained if possible in co-operation with the Medical Council—to secure to the members of their society the right to continue their present calling, and approved the answer to this communication which had been sent by the Registrar by direction of the President.

On the motion of Dr. Windle, seconded by Dr. Norman Moore, the report was received and entered on the minutes.

VISITATION AND INSPECTION OF QUALIFYING EXAMINATIONS.

The Executive Committee presented a series of revised standing orders for adoption by the Council relating to the visitation and inspection of qualifying examinations.

The President said that at the last meeting some ambiguity was discovered in the standing orders, and the Executive Committee had considered the matter, and the orders now proposed were the result of its consideration. The only question was whether they would express more clearly what the Council had acted upon for years. There was no change.

Dr. Windle moved the adoption of the first rule, viz.:—

(1) The qualifying examinations of the several licensing bodies in the three divisions of the kingdom shall be visited and inspected on behalf of the Council from time to time as the Council shall direct.

Dr. McVail said that he had no objection to the rule if it were interpreted in the sense that visitation and inspection were to be distinct and different. If visitation and inspection meant the same thing, he asked that the matter should be further looked into.

The President said that Dr. McVail was anticipating the discussion on the other rules. They had more

than one legal opinion that visitation was a right conferred upon them by the Act of 1858 which could be carried out at any time they pleased, and that inspection was a right conferred upon them by the Act of 1886 which could also be carried out at any time. Therefore inspection and visitation could be carried out together if they thought fit. This rule did not force them to combine the two if they chose not to do so. He would point out that the tenth rule said that it would be the duty of the visitors and inspector to report "jointly or severally." The word "reports" was also used.

The motion was agreed to.

The second standing order was also approved after some discussion. Its terms were:—

The visitations shall be conducted by one or more members of the Council deputed as visitors for that purpose, in pursuance of Section 18 of the Medical Act, 1858; the inspections by an inspector not a member of the Council, appointed in pursuance of Section 3 (2) of the Medical Act, 1886.

At this stage the Council adjourned till the following day.

WEDNESDAY, MAY 24TH, 1905.

The minutes of the last meeting were read, amended and confirmed.

After certain matters had been considered *en camera*, the Council proceeded to the consideration of the case of Percival Humble Watson, registered as of the Grand Hotel, Trafalgar Square, London, W.C., M.R.C.S.Eng. 1873, L.R.C.P. Lond. 1876, who had been summoned to appear before the Council to answer the following charge, as formulated by the Council's solicitor:—"That you abused your position as a medical man by committing adultery with a patient, namely, Mrs. Manford, a married woman, whom you had been and were attending professionally, of which adultery you were found guilty by decree of the Probate, Divorce, and Admiralty Division (Divorce) of the High Court of Justice." Mr. Watson did not attend in answer to his notice, but was represented by Mr. F. Marshall, of Messrs. Wilkinson and Marshall, solicitors, of Newcastle-on-Tyne. Mr. D. McMillan, solicitor, of 11 and 12, Clements Lane, E.C., appeared on behalf of Mr. John Stanley Manford, the complainant, who was also present, together with Mr. A. J. Langstaff, managing clerk to Messrs. Stanton and Atkinson, solicitors, of Newcastle-on-Tyne, a witness in the case. Mr. Winterbotham having read the notice, Mr. McMillan read a declaration by Mr. Manford, and put in a copy of the *decree nisi*. Mr. Manford was then called as a witness at the request of Mr. F. Marshall, who examined him as to certain statements in his declaration. He also examined him generally as to the facts of the case. Mr. Marshall objected to the reception of the declaration by Mr. A. J. Langstaff. The objection was over-ruled. He then proceeded with the examination of Mr. Manford. Mr. McMillan next read the declaration by Mr. Arthur James Langstaff, and tendered him as a witness. Mr. Langstaff answered a question put to him from the Chair. He was then cross-examined by Mr. Marshall. This closed Mr. McMillan's case.

Mr. Marshall then addressed the Council on behalf of Mr. Watson, in support of the adultery not having been committed during the time in which the lady was Dr. Watson's patient, and read a letter which had been written on his behalf by Messrs. Wilkinson and Marshall. Mr. Manford and strangers having by direction of the Council withdrawn, the Council deliberated on the case *en camera*. Mr. Manford and strangers having been readmitted, the President announced the decision of the Council as follows:—"Mr. Marshall, I have to inform you, as representing Mr. Watson, that the Council have found proved the facts alleged against him in the notice of inquiry; that they have adjudged him to have been guilty of infamous conduct in a professional aspect, and have

directed the Registrar to erase from the *Medical Register* the name of Mr. Percival Humble Watson."

The Council proceeded to the consideration of the case of William Patrick Kirwan, registered as of 21, Danbury Street, Islington, N. Lic. R. Coll. Phys. Edin. 1882, Lic. R. Coll. Surg. Edin, 1882, 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 associated yourself with a Medical Aid Association—namely, a firm of chemists trading at various addresses as The Acme Medical Hall and Pharmacy—which Association has systematically, by means of printed circulars, cards, labels, and notices, printed and painted, advertised your practice, name, and qualifications, and thereby canvassed for patients for you. (2) That you have enabled certain persons in the employ of The Acme Medical Hall and Pharmacy to practise medicine, and to treat patients as if qualified by law to do so." Mr. Kirwan attended in answer to his notice, accompanied by Mr. H. Pearce and Mr. G. R. Carpenter, his dispensers, as witnesses. Dr. Bateman attended on behalf of the Medical Defence Union, the complainants, accompanied by Mr. Hempson, of 35, King Street, Cheapside, E.C., solicitor, and Mr. Thomas William Tyrrell, a witness. Mr. Winterbotham having read the notice to attend, Dr. Bateman proceeded to open his case. He read correspondence which had passed between himself as Secretary to the Medical Defence Union and Mr. Kirwan with reference to the issue of certain circulars. Dr. Bateman then called Mr. Thomas William Tyrrell, clerk to Messrs. Hempson, as a witness, and examined him at to the facts set forth in his declarations, especially with reference to his having visited at various times the dispensaries of the defendant, and his having been supplied with bottles of medicine in the absence of Mr. Kirwan, etc. Mr. Tyrrell answered a question put to him by Mr. Kirwan. He also answered questions put to him from the Chair, and by members of the Council through the Chair. He was then re-examined by Dr. Bateman. Mr. Kirwan addressed the Council on his own behalf, pleading that any errors he committed in London were only done in error, as he had arrived from the West of Ireland, and called Mr. G. R. Carpenter, one of his dispensers, as a witness, who stated that he had never acted as a medical man, but had only made up prescriptions from Mr. Kirwan's note-book. Mr. Carpenter was cross-examined by Dr. Bateman, and answered questions put to him from the Chair. He was re-examined by Mr. Kirwan. Mr. Kirwan called Mr. H. Pearce, another dispenser, as a witness, and examined him. He was cross-examined by Dr. Bateman. Mr. Kirwan tendered himself as a witness, and was examined by Dr. Bateman. He also answered questions put to him from the Chair, and by members of the Council through the Chair. This closed Mr. Kirwan's case. Dr. Bateman stated that he did not desire to address the Council in reply. Strangers having, by direction of the Council, withdrawn, the Council deliberated on the case *en camera*. Mr. Kirwan and strangers having been readmitted, the President announced the decision of the Council as follows:—Mr. Kirwan: The Council has decided that the facts alleged against you have been proved to their satisfaction; they have adjourned their decision in your case till the next Session in November, when their judgment on the facts will be influenced by the information which they will have received in regard to your conduct in the interval, more particularly in regard to canvassing, advertising, and the employment of unqualified assistants, with respect to which matters they will require satisfactory assurances at the adjourned hearing.

The Council then adjourned.

THURSDAY, MAY 25TH, 1905.

DR. MACALISTER, President, in the Chair.

THE minutes of the last meeting were read, amended and confirmed.

The Council then proceeded to the consideration of the case of Alexander Christie McArthur, registered as of the Grafton, Clarence River, New South Wales M.B., M.S. University of Glasgow, who had been summoned before the Council to answer the following charge as formulated by the Council's solicitor:—" That you abused your position as a medical man by eloping with a patient, Mrs. K—, a married woman, whom you had been and were at the time attending professionally." Mr. McArthur did not attend in answer to his summons, nor was he represented by counsel or a solicitor. Mr. W. F. A. K—, the complainant, attended to assist the Council in regard to the case, and applied that the Council might hear the case *in camera*. On question put from the chair, the Council agreed to hear the case *in camera*. At the conclusion of the hearing of the case strangers were re-admitted, and the decision of the Council was announced from the chair as follows:—That the charge against Alexander Christie McArthur had been proved to the satisfaction of the Council; that the Council had judged him guilty of infamous conduct in a professional respect, and had directed the Registrar to erase from the Register the name of Alexander Christie McArthur.

The Council proceeded to the consideration of the case of William Jones, in regard to whom the Dental Committee had found the following facts:—

REPORT ON THE CASE OF WILLIAM JONES.

On May 22, 1905, the inquiry was held. Mr. William Jones was personally present, and was represented by counsel, Mr. Hugo Young, K.C., instructed by Messrs. Style, Lindsay, and Squarey, of Liverpool solicitors. The Dental Association appeared by counsel, Mr. R. W. Turner, instructed by Messrs. Bowman and Curtis-Hayward, solicitors. Notice of the inquiry was read. The Committee find that the following facts were established by the evidence:—(1) William Jones was registered in the *Dentists' Register* on November 28th, 1878, as in practice before July 22nd, 1878, and his address in the *Dentists' Register* is The Arcade, 85, Lord Street, Liverpool. (2) Being a registered dentist he has sought to attract business by a system of extensive public advertisements of an objectionable character, containing his name, address, and qualifications, praising his own professional skill and preparations, instituting comparisons between his own work and that of other practitioners, and claiming superiority over other practitioners and depreciating their work. (3) The said William Jones personally and in a letter to the Solicitor of the Council, dated May 19th, 1905, undertook not to advertise in such a way as to praise his own professional skill and preparations, nor to institute comparisons between his own work and that of other practitioners, nor to depreciate their work, nor to claim superiority over them, nor to issue any advertisements containing his photograph. (4) The evidence before the Committee consisted of: (a) Advertisements by the said William Jones in two pamphlets issued and circulated by the said William Jones in two editions. "The Incorporated Trade Protection Society Circular," November 2nd, 1904; "Torrey-Alexander Mission Record," November 19th, 1904; "The Porcupine," February 4th, 1905; a handbill headed "Anodynol J, registered," produced by the said William Jones; and other publications admitted by the said William Jones. (b) A statutory declaration of Thomas Woods, of 76, Bradford Street, Bolton, private inquiry agent, and two exhibits thereto being the earlier edition of the two above-mentioned mentioned pamphlets issued and circulated by the said William Jones. (c) The statements and admissions of the said William Jones made before the Committee. Mr. Jones attended in answer to his notice, accompanied by Mr. Hugo Young, K.C., his counsel, instructed by Messrs. Style, Lindsay and Squarey, solicitors, of Liverpool, and accompanied by Mr. Barham, of Messrs. Sharp, Parker and Co., of New Court, W.C., their London agent. Mr. R. W. Turner appeared on behalf of the British Dental Association, the complainants, instructed by Messrs. Bowman and

Curtis-Hayward, solicitors, and accompanied by Mr. Curtis-Hayward, junior. The Registrar having read the report of the Dental Committee, the Council, on question put from the chair, agreed to hear the parties to the case. Mr. Hugo Young addressed the Council urging that although the advertisements were not in good taste, they were not infamous in a professional sense, and asking the Council to grant time to Mr. Jones. Mr. Turner then addressed the Council in reply, laying stress on the point that a professional man should not act as a tradesman. Strangers having by direction of the Council, withdrawn, the Council deliberated on the case *in camera*. Mr. Jones and strangers having been re-admitted, the President announced: "That on the facts found in the report of the Dental Committee it has been proved that William Jones has been guilty of conduct which is infamous or disgraceful in a professional respect, and the Council has directed the Registrar to erase from the *Dentists' Register* the name of William Jones."

The Council proceeded to the consideration adjourned from Tuesday, May 23rd, when they were entered on the minutes of the revised standing orders recommended by the Executive Committee for adoption by the General Council.

Moved by Dr. McVail, seconded by Mr. Young, and agreed to:—"That the proposed Revised Standing Orders relating to the Visitation and Inspection of Qualifying Examinations be remitted back to the Executive Committee for further consideration, and in particular that the Committee should consult counsel as to the agreement of the proposed Standing Orders with Section 3 of the Medical Act of 1886."

Moved by Dr. Bruce, and seconded by Sir John William Moore, and agreed to, "That the report from the Public Health Committee be received and entered on the minutes."

The Committee recommended that the following additions be made to the Rules:—1. In Rule 3 after (c) insert—"Outside the United Kingdom, Medical Officer of Health of a Sanitary District having a population of not less than 30,000, who himself holds a registrable Diploma in Public Health; or . . ." 2. As a Note to Rule 3 add—"Note (3).—A candidate who shall have produced evidence that he has himself held for a period of not less than three years an appointment as Medical Officer of Health of a Sanitary District having a population of not less than 15,000 may be exempted from the requirement of Rule 3."

Dr. Bruce moved, and Dr. Lindsay Steven seconded, that (2) should be adopted.

Dr. McVail moved as an amendment, seconded by Sir John Tuke, "That the operation of the proposed Note 2 to Rule 3 be limited to five years from that date. The amendment was lost: absent 3, 17 against, 3 for; 10 did not vote.

Further amendment moved by Sir William Thomson, seconded by Mr. Jackson:—"In the proposed Note, after the word 'district' to insert the words 'within the British dominions, and,'"

Dr. Bruce, with the consent of his seconder, accepted the amendment, and the original motion, as thus amended, was then put and carried.

The Council proceeded to the consideration of the case of Herbert Du Cane, registered as of 56, Bolton Road, Darwen, Lancs., Lic. Soc. Apoth. Lond., 1890, who had been summoned to appear before the Council to answer the following charge, as formulated by the Council's solicitor:—"That you abused your position as a medical man by committing adultery with a patient, namely, Mrs. Taylor, a married woman, whom you had been and were attending professionally. Dr. Du Cane did not appear in answer to his summons, but was represented by Mr. W. C. Danckwerts, K.C., and Mr. Ellis Griffith, M.P., his counsel, instructed by Mr. J. T. Bayes, of Edwards and Cohen, solicitors, of Audrey House, Ely Place, E.C. The Darwen Medical Society, the complainants, were represented by Mr. F. G. Hindle, of Messrs. Hindle and Son, solicitors, of Darwen, accompanied by his London agent, Mr. T. R. Haslam, of Messrs. Haslam and Co., solicitors, of

Moorgate Street, E.C., and Mr. T. H. Taylor, the husband, was also present as a witness. Mr. Winterbotham read the notice to attend, and Mr. Hindle then opened the case for the complainants. He read the letter of confession which had been written by Mr. Du Cane to Mr. Taylor, and a declaration by Mr. Taylor as to Mr. Du Cane's professional relations with himself and family, and the dates of attendance, which he put in. He also read a declaration by Mr. William Standing, a chemist, who had made up a prescription of Mr. Du Cane's for Mr. Taylor in January, 1904, and a declaration by Alice Perkins Fisher, a domestic servant in Mr. Taylor's employment, as to the dates of Mr. Du Cane's attendance, both of which documents he put in. He then tendered Mr. Taylor as a witness and examined him. He was cross-examined by Mr. Danckwerts. Mr. Taylor answered a question put to him from the chair, and was then severely re-examined by Mr. Hindle. Mr. Danckwerts then addressed at some length the Council on behalf of Mr. Du Cane, and read two statutory declarations which had been made by him. He also read two declarations which had been made by Mrs. Taylor. Mr. Hindle then addressed the Council in reply, and the Council having deliberated *in camera*, the President, on the re-admission of strangers announced the decision of the Council as follows:—"Mr. Danckwerts, I have to inform you, as representing Herbert Du Cane, that the Council have found proved the facts alleged against him; further that they have judged him to be guilty of infamous conduct in a professional sense, and have directed the Registrar to erase from the *Medical Register* the name of Herbert Du Cane."

FRIDAY, MAY 26TH.

The minutes of the last meeting were read, amended, and confirmed.

The following recommendation of the Public Health Committee: To insert in Rule 3, after (c)—"Outside the United Kingdom, a Medical Officer of Health of a sanitary district having a population of not less than 30,000, who himself holds a registrable Diploma in Public Health; or —" was adopted with the suggestion to prefix to it: "Within the British Dominions."

Moved by Dr. Windle, seconded by Dr. Norman Moore, and agreed to: "That the Report from the Education Committee be received and entered on the minutes." The report dealt chiefly, in the first place, with the question of the possibility of including certain subjects in the curriculum without requiring examination in them. The committee had endeavoured to ascertain if any light could be thrown on the subject by Continental experience. In the second place, it had replied to the University of London, which body had applied for the recognition of a junior schools examination, not qualifying for matriculation of the University, that it was at present unable to comply with any application of this kind.

A motion of Dr. Mackay, seconded by Sir John Batty Tuke: "That it be remitted to the Education Committee to prepare and present to the Council a detailed Report upon the system of examination in medicine followed in other countries with the special object of determining the number of professional examinations demanded, the subjects included in these examinations, and the value (if any) attached to the records of class attendance and work"—was lost.

Moved by Dr. Pye-Smith, seconded by Mr. Tomes, and carried: "That the report of the Finance Committee be received and entered on the minutes." This report was satisfactory.

Moved by Dr. Pye-Smith, seconded by Mr. Tomes, and carried: "That a grant of £100, should it be required, be made towards the expenses of the Irish Branch Council during the current year."

A vote of thanks to the Treasurers was moved by Dr. Bruce, seconded by Sir Christopher Nixon, and carried unanimously.

Moved by Sir Patrick Heron Watson, seconded by

Mr. Young, and agreed to: "That the report of the Examination Committee on the inspection of the final examination of the University of Oxford be received and entered on the minutes." Before the motion for the approval and adoption of this report had been agreed to, several speakers, amongst whom were Mr. Jackson and Sir Thomas Myles, addressed the Council on the great importance of the performance of operations on the dead body at examinations, which was not carried out to a large extent at Oxford, and Mr. Thomson made an able speech in defence of his University.

The report of the Examination Committee on the inspection of the final examination of the University of London, was, on the motion of Sir P. Heron Watson, seconded by Mr. Young, received, entered on the minutes, and approved.

Moved by Dr. McVail, seconded by Sir John William Moore, and carried: "That it be remitted to the Examination Committee to prepare and present to the Council, at its May Session next year, a general report on the whole cycle of visitations and inspections of the final examinations."

Moved by Sir P. Heron Watson, seconded by Mr. Young, and agreed to: "That the report from the Examination Committee on the statistics arising out of the returns of examinations for entrance to the Navy, Army, and Indian Medical Services be received and entered on the minutes." This report dealt with the question of the percentage of rejections at these examinations.

By request of the President, who is chairman of the Pharmacopœia Committee, Dr. Norman Moore proposed, and Sir John William Moore seconded: "That the report of this Committee be received and entered on the minutes." This was agreed to.

Moved by Mr. Tomes, seconded by Mr. Brown, and agreed to: "That the report from the Dental Education Committee be received and entered on the minutes."

Moved by Mr. Tomes, seconded by Dr. Bennett, and agreed to: "That recommendation (i) in the report of the Dental Education and Examination Committee be adopted—viz., (i) That the Registrar be instructed to accept for the purposes of registration upon the 'Dentists' Register' the licence in dental science of the University of Dublin, and the Licence in Dental Surgery of the Victoria University of Manchester (Dentists Act, Sec. 6 (a))."

Moved by Mr. Tomes, seconded by Dr. Lindsay Steven, and agreed to: "That recommendation (ii) in the report of the Dental Education and Examination Committee be adopted—viz., (ii) That the degrees in dental science and in dental surgery granted by the same Universities be recognised for entry upon the 'Dentists' Register' as 'additional diplomas, memberships, licences' . . . granted in respect of a higher degree of knowledge" (Dentists' Act, Sec. 11 (6))."

Moved by Mr. Tomes, seconded by Dr. Lindsay Steven, and agreed to: "That inspection and visitation in the ordinary sense being at present impracticable, the offer of the Dental Board of Victoria, Australia, to submit candidates' papers, marks, and returns generally to the Registrar be accepted."

Moved by Mr. Brown, seconded by Mr. Jackson, and agreed to: "That the President be authorised to take the opinion of the legal advisers of the Council as to whether degrees granted in dental science and dental surgery by Universities in the United Kingdom are registrable as primary qualifications to practise dentistry."

Moved by Dr. Windle, seconded by Sir Victor Horsley, and agreed to: "That a communication from the British Medical Association dealing with the ethics of the Profession be received and entered on the minutes, and also as a second motion be remitted to the Executive Committee, with a request for them to confer with the legal advisers of the Council on the subject, and if considered advisable, to draft a form of notice of warning to medical practitioners for consideration at the next meeting of the Council."

Moved by Mr. Brown, seconded by Mr. Jackson:

"That from and after July 1st next, the remuneration for attending meetings of the Council and Executive Committee shall be three guineas per diem instead of five guineas as at present, and that the standing order be amended accordingly." This motion was lost.

Moved by Sir Hugh Bevor, seconded by Mr. Moore, and agreed to: "That Mr. W. McAdam Esq. F.R.C.S., be appointed as assistant examiner in surgery to the Apothecaries' Society of London for a period of four years, *vice* Mr. Bruce Clarke, who retires by rotation."

SATURDAY, MAY 27TH.

The minutes of the last meeting were read and confirmed.

Moved by Mr. Brown, and seconded by Mr. Young: "That representations be made to the Privy Council that the time has arrived when the number of Delegates Representatives for England, Scotland, and Ireland should be increased to the maximum number permitted by the Medical Act, 1886." After a discussion in which Dr. McVail, Sir William Thomson, Dr. Lindsay Steven, and Dr. Caton took part, the motion was lost—10 for, 18 against; 5 did not vote.

Moved by Sir John Williams, seconded by Dr. McVail, and agreed to: "That a Committee of the Council be appointed to inquire into the operation of the rules regarding the Midwifery practice required of candidates for Medical qualifications."

The Council elected the following members—
On the Executive Committee—Dr. Pye-Smith, Sir Hugh Bevor, Sir John Tuke, Sir William Thomson, Mr. Young, Mr. Tomes, Sir P. Heron Watson, Sir Christopher Nixon.

On the Penal Causes Committee—Sir Hugh Bevor, Dr. Windle, Sir Christopher Nixon, Sir William Thomson, Sir Victor Horsley, Dr. Finlay, Sir P. Heron Watson, Mr. Tomes.

Moved by Sir Hugh Bevor, seconded by Sir Victor Horsley, and agreed to: "That the report of the Students' Registration Committee be received and entered on the minutes."

Moved by Sir William Thomson, seconded by Dr. Norman Moore, and carried: "That the Executive Council be requested to consider, in consultation with the legal advisers, whether they can advise the Council as to the form of indictment in penal cases, so as to enable the Council to come to a decision on each case separately."

Moved by Dr. McKay, seconded by Dr. Lindsay Steven, and carried, after a discussion: "That it be remitted to the Finance and Executive Committees to take into consideration the suggestion made by the President in his address at the opening of the present session to the effect that a small fee might with advantage be charged for Students' Registration."

Moved by Dr. Bruce, seconded by Dr. Norman Moore, and agreed to: "That it be recorded on the minutes, in accordance with the resolution adopted on November 29th, 1904 (Vol. XLI., p. 149): 'That in the opinion of the Council it is desirable that when new or amended regulations are adopted by the Council a formal statement should be placed on the minutes as to the effect of the new or amended regulations upon previous regulations on the same subject. That the following recommendations of additions to be made to the rules for Diplomas in Public Health—namely: 'That the following be added as a note to Rule 3: 'Note (3). A candidate who shall have produced evidence that he has himself held for a period of not less than three years an appointment as Medical Officer of Health of a sanitary district within the British Dominions, and having a population of not less than 15,000, may be exempted from the requirements of Rule 3.' (Adopted on May 25th, 1905.)' In Rule 3, after (c), insert—'Outside the United Kingdom, a Medical Officer of Health of a sanitary district having a population of not less than 30,000, who himself holds a registrable Diploma in Public Health; or, . . . ' (Adopted on May 26th, 1905)—are additions to the rules for

Diplomas in Public Health, but involve no further alterations in the existing rules."

The following members were then appointed:—

On the Examination Committee—Dr. Pye-Smith, Mr. Young, Dr. Caton, Sir P. Heron Watson, Dr. Finlay, Dr. McVail, Dr. Little, Sir William Thomson, Sir T. Myles.

On the Education Committee—Dr. Windle, Dr. Norman Moore, Sir G. Philipson, Dr. Mackay, Sir John Tuke, Dr. McCall Anderson, Sir W. Thomson, Dr. Bennett, Sir C. Nixon.

On the Public Health Committee—Sir G. Philipson, Mr. Power, Mr. Jackson, Dr. Bruce, Dr. Lindsay Steven, Dr. McVail, Dr. Bennett, Sir J. William Moore, Sir T. Myles.

Pharmacopœia Committee—Chairman, the President; Dr. N. Moore, Sir G. Philipson, Sir J. Batty Tuke, Dr. McVail, Sir John Moore, Dr. Little.

Dental Committee—Chairman, the President; Mr. Morris, Mr. Tomes, Sir P. Heron Watson, Sir T. Myles.

Dental Education and Examination Committee—Chairman, Mr. Tomes; Mr. Morris, Mr. Brown, Dr. Lindsay Steven, Dr. Finlay, Dr. Bennett, Sir T. Myles.

Students' Registration Committee—Chairman, Sir Hugh Beevor; Sir J. Batty Tuke, Dr. Mackay, Dr. Bennett, Sir W. Thomson, Dr. McCall Anderson.

Mr. Allan was appointed General Registrar.

Dr. Norman Moore, seconded by Sir T. Myles, moved a vote of thanks to the President, which was cordially carried.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

SCOTLAND.

BANGOUR VILLAGE ASYLUM.—A further step towards the complete working of this asylum was taken on May 17th, when the railway, which has been built to afford access to the asylum buildings, was formally inspected by the Board of Trade Inspector, who at the close of his visit expressed his entire satisfaction with the manner in which the line had been laid. Thereafter the asylum itself was visited; for some time past there have been 200 patients in residence in temporary iron and wood pavilions pending the completion of the permanent structures. The Bangour Asylum and the District Lunacy Board have been the subject of a great deal of criticism during the past few years, and probably comparatively few are aware of the exact circumstances under which Edinburgh has never, until quite recently, been called upon to provide an asylum for a pauper lunatic. From 1842 the insane poor were treated in Morningside Asylum, which claimed all these sufferers as its especial care, so that, while under the Act of 1857 other towns and counties had built asylums of their own and developed them as need arose, Edinburgh was only called upon to face the question about four or five years ago, when intimation was made that the Morningside Asylum had no longer space to receive such patients. A compromise was however, effected, whereby the asylum authorities agreed to take a certain number of patients for a limited period, while the City of Edinburgh was formed into a separate lunacy district. Face to face with the problem of providing for about a thousand of the pauper insane as speedily as possible, the General Lunacy Board, in whose hands the final decisions as to sites, plans and estimates lie, urged the District Board to adopt the "village system" so strongly advocated by the late Sir John Sibbald, and in consequence of this the Bangour estate was purchased at a very cheap rate—at about £15 an acre. Since the first purchase of 900 acres, land for the construction of a reservoir has been acquired, and practically the whole of a small village adjacent, but the total cost of the site may be put at £23 an acre—a very low figure as compared with that paid for land for many other undertakings near

the city. The village is now rapidly approaching completion, and may be ready for the accommodation of patients by this time next year. At present it is designed for 750 inmates, but the administrative buildings are on a larger scale, so that ultimately the asylum will be sufficient for 1,000 patients, and there is ample ground on all sides for extension beyond that number. It has been suggested that on a sunny slope near the western boundary of the asylum grounds a municipal sanatorium for poor consumptives might be built, and it is understood that a movement in this direction is on foot.

ROYAL INFIRMARY RESIDENTS' CLUB.—The eleventh annual meeting of this club will take place on June 30th, at 6.30 p.m., in the Caledonian Station Hotel, Edinburgh. Professor Annandale, President of the club, will occupy the chair at the dinner which follows the meeting.

VISIT OF THE CHANNEL FLEET TO THE FORTH.—The Royal College of Physicians seized the occasion of the Fleet's visit to Edinburgh to entertain the medical officers to luncheon in the hall of the College on May 22nd. The guests present were: Fleet-Surgeons Home, Fasken, Meaden, Hughes, Brodley, Holyoake, Acheson, Levinge, Luther, and Maitland; Staff-Surgeons May and Stephens; and Surgeons Lockwood, Gardner, Smith, Elles, Johnstone, and Herbert.

BELFAST.

ACTION AGAINST AN INFIRMARY SURGEON.—A case which caused more amusement than anxiety was heard at the Belfast Recorder's Court last week, when a lady who had the honour of cooking for the resident medical staff at the Union Infirmary brought an action for assault against one member of that staff. It seems that complaints concerning the quality of the food supplied to the doctors have been frequent and free, and the plaintiff alleged that the doctor in question had not only complained, but had threatened personal violence, and had finally given her a push. She admitted that he had not hurt her, except in her feelings, but following a high authority she claimed compensation for "moral and intellectual damages." Happily for the young doctor, he was able to produce evidence that he was quite guiltless of anything more than a stern remonstrance at the quality of the bread, and the case was dismissed.

MEDICAL MISSIONARY MEETINGS.—On the afternoon and evening of Friday, May 26th, meetings were held in connection with the Church Missionary Society, at which addresses were delivered by Dr. J. Howard Cook, of Mengo, Uganda. Sir William Whitla, M.D., presided in the afternoon, and Professor Lindsay, F.R.C.P., in the evening, and a number of medical men of various denominations attended to hear some account of the medical work done in Uganda, and especially an account of the present plague of the country—sleeping sickness. Though no treatment is of any avail as yet and all cases prove fatal in a few months, Dr. Cook expressed great hope that the recent advances in our knowledge of the pathology of the disease may soon lead to the knowledge of some useful treatment, even if only to allay the great suffering of the early stages.

Correspondence.

RECURRENCE OF WINTRY WEATHER IN BRITAIN IN SPRING.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—With reference to my letter on the recurrence of wintry weather at Edinburgh, published in the *Meteorological Magazine* for May, I regret to intimate that a singular confirmation of the popular warning against a *cold week in May* has occurred here in the decease of two members of a club in town. One had gone on a visit to London, and caught a chill in the Park, which developed into *pneumonia* and pleurisy, for which he was operated on, and succumbed eventually; and the other case was that of a gentleman who died of *pneumonia*, caught by exposure here to the phenomenal cold blasts in the streets.

Independent of instrumental observations, the week

was characterised by the prevalence of *east winds*—north-east to south-east—and persistent *absence of rain*, which has lasted now for three weeks. The *drought* has caused the roads in the country to be inches deep in dust, and the streets in the towns to be covered with detritus of manure, sand, and asphalt. This *polluted* road atmosphere would be enough of itself to infect the lungs of travellers and tend to occasion *fatal illness*, apart from the mere chilliness of the air, which is given warning to the public by the common distich, "ne'er cast a clout till May be out."

I am, Sir, yours truly,
W. T. BLACK, F.R.C.S.E.

Edinburgh, May, 1905.

"IRISH MEDICAL DIRECTORY" FOR 1905.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—There are a few points connected with the origin and birth of the "Irish Medical Directory" for 1905, which should be explained for the credit of the Council and the general body of the I.M.A., more especially as the little one is so badly deformed that it can only be looked upon by the profession as a monstrous production. The conception was irreproachable, but the product was blighted in the third month and its future development so completely arrested that an abortion was only with the greatest difficulty avoided. However, premature delivery could not be prevented, and, although the infant shows very little vitality and presents many objectionable features, still it may be looked upon as a promising youngster, and with extra care and attention may really develop into a useful handmaiden.

As to its origin and the responsibility of the Council for the manner of its production, it is only right that it should be known that it was due to the suggestion thrown out by the President in his opening address in June last; which suggestion he repeated to the Committee of Council, who eagerly took the matter up and, without consulting the Council, voted the Hon. Secretary £15 to help in carrying the suggestion into effect. The Council of the Association never was consulted, nor can it be considered in any way responsible. The Association itself is indirectly responsible for having such an organisation as permits the Committee of Council to act independently of the Council, but it is hoped that the new scheme which is now being worked out will prevent such contingencies in the future. I am satisfied that next year's issue will leave very little to find fault with. Dr. Donnelly, the Hon. Secretary, has already announced that the qualifications, etc., of every member of the profession who fills in the slip will be inserted, whether he belongs to the Association or not. It was unfortunate that unavoidable circumstances should frustrate his intentions at the outset, but next year it is to be hoped that there will be nothing to complain of.

I remain, yours, &c.,
SAML. AGNEW,
Member of Council, I.M.A.

[Where has the announcement referred to in the penultimate sentences been made, and what steps have been taken to bring it to the notice of non-members? Further, how are the qualifications, etc., to be ascertained?—Ed.]

THE KING'S FUND AND THE MANAGEMENT OF HOSPITALS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I cannot allow the erroneous statements of F.R.C.S. to pass without protest. Before writing a letter upon such an important subject in common fairness he should be certain of his facts. He says:

"They appealed to Cæsar while in a dilemma, and consequently should abide by Cæsar's decision."

And so they would if the decision had not been *ultra vires* and on points about which no opinion was asked.

The King's Fund was asked to adjudicate as to the justness of the late staff's allegations against the management of the hospital. It was proved that the matters complained of were some years old, and had long been remedied. On the strength of this the amazing decision is given that the hospital is unnecessary and should be converted into a dispensary, that the new staff should resign and that a M.R.C.S. is not (in the absence of bye-laws to the contrary), entitled to hold a hospital appointment. And this, notwithstanding letters written by the Commissioner himself some time previously to the effect that the hospital was greatly needed in the district. These letters, although forming part of the hospital Board's answer to the report of the Commissioners, were suppressed by the "British Medical Journal" and the report printed without them. As regards the decision as to the M.R.C.S. diploma, if it were worth a moment's consideration it would be calculated to have far-reaching effects as lowering the value of the qualification all over the world. F.R.C.S. states that after the late staff had resigned "instead of the Board proceeding to deal with the matter by taking steps to profit by the advice of the late staff, they calmly apply for candidates to fill the appointments." The late staff did not suggest an inquiry but asked the board to fill up their places as soon as possible. This was done, and consequently F.R.C.S. is entirely wrong in saying that the Board did not profit by the advice of the late staff, whose suggestions, as a matter of simple fact, they followed to the letter.

I am, sir, your truly,
M. D.

THE INQUEST ON THE MASK MURDERERS (STRATTON).

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In the accounts of the late executions of the brothers Stratton for murder, the autopsy was stated to have been performed by Dr. Freyberger (of course, as Mr. Troutbeck was the Coroner). Why was not the autopsy carried out by the medical officer of the gaol, Dr. Beamish? It looks as if Dr. Freyberger was to monopolise all *post-mortems* in future.

I am, Sir, yours truly,
OBSERVER.

Obituary.

GEORGE LONGBOTHAM, M.R.C.S.ENG.,
L.S.A.LOND.

We regret to record the death of Mr. George Longbotham, at the age of fifty-nine, from cancer. He was educated at the Newcastle School of Medicine, and after obtaining the diplomas of M.R.C.S. and L.S.A., in 1867, joined his uncle in practice in county Durham, afterwards removing to Leeds, and subsequently to Middlesbrough, where he practised for twenty-six years, leaving for Ilkley and then for Harrogate. He was Medical Officer to the Union Infirmary, and on the staff of the North Riding Infirmary, Middlesbrough, for many years, and a Past Master of the Ferrum Lodge of Freemasons. He leaves a widow, one daughter, and eight sons, the eldest of whom is practising in Middlesbrough.

ALAN BELL, M.A., M.D.DUB.

The death took place at Derby on the 19th instant, of Dr. Alan Bell, a well-known medical practitioner in the town, at the early age of 41. He had not been well for some time but it was only ten days before death that his condition gave rise to serious apprehension. It then became apparent that he was suffering from meningitis. Dr. Bell studied at Dublin University, where he obtained the B.A. degree in 1884. Two years later he became Bachelor of Medicine, and in 1890 he graduated M.A. and M.D. He went to Derby from Dublin about fourteen or fifteen years ago, succeeding to the practice of the late Dr. Hutchings. He leaves a widow, but no family.

JOHN FRANCIS SCOTT FOWLER, M.B., C.M.ABER.
 THE death of Dr. J. F. S. Fowler, of the Public Hospital, Georgetown, British Guiana, which took place on March 2nd, is a great loss to the colony of British Guiana. He had been ailing for a few days from hospital sore throat. Then oedema of the glottis supervened, and although tracheotomy was performed, he died almost immediately.

Literature.

DISEASES OF THE LIVER. (a).

THIS is a bulky book of nearly 800 pages and many illustrations, plain and coloured. It can hardly be described as a text-book, for it partakes too much of the character of an index-catalogue. It teems with references, of which there are, on an average, from ten to a dozen on every page. The whole field of literature has been laid under contribution, and French, German, American, and English authors are quoted galore. Statistics are employed so lavishly that in many instances they serve only to obscure the facts. It is a careful and laborious work, but contains much undigested and undigestible material. In spite of these imperfections, there is an abundance of interesting information dealing with modes of treatment and pathological conditions not commonly given in ordinary works on medicine. Under the heading of "Cirrhosis," we have an account of the surgical treatment of ascites by the production of vascular peritoneal adhesions, stress being laid on the necessity for the early performance of the operation. Curiously enough, on this particular point the bibliography is by no means full, and is in some respects decidedly deficient. Speaking of the treatment of syphilitic diseases of the liver, the author recommends that "iodide of potassium should be combined with iodide of sodium, and with an ammonium salt such as spiritus ammoniæ aromaticus." We are told that "in this way the depressing effects of the potassium are avoided." It is hardly correct to speak of the aromatic spirit of ammonia as an ammonium salt, and one cannot help wondering why, if it is desired to avoid the action of the potassium salt, the iodide of sodium or of ammonium should not be prescribed as such without the circumlocution.

There are scattered throughout the book many curious and interesting cases collected from many different sources. There are probably few men even in hospital practice who are practically familiar with paramœcia of the liver or who could give straight off the symptoms of carcinoma of the ampulla of Vater. Pigmentary cirrhosis of hæmochromatosis, in other words, diabete bronze, is well described, and there is a plate showing the pigmentation of the liver cells and fibrous tissue. Cholelithiasis is an excellent article, the classification of gall-stones according to their chemical composition being quoted from Naunyn. There is a good description of an attack of biliary colic and the differential diagnosis is given between that condition and such dissimilar diseases as renal colic, floating kidney, gastric and duodenal ulcer, acute dyspepsia, hyperchlorhydria, appendicitis, mucous colitis, intestinal lithiasis, angina pectoris, lead colic, acute pancreatitis, and the hepatic crises of tabes. It is not a perfect work, it is better fitted for the shelves of a library than for the consulting-room table, but the author has done his work well, and we are grateful to him.

A DONATION of £1,000 has just been received by the Special Appeal Committee of St. Bartholomew's Hospital from the trustees of Smith's Kensington Estate Charity.

THE annual meeting and *conversazione* of the Royal British Nurses' Association will be held in the Gardens of the Royal Botanic Society of London, on Wednesday, next, June 7th.

a) "Diseases of the Liver, Gall-bladder, and Bile-Ducts." By H. D. Rolleston, M.A., M.D. F.R.C.P., Physician to St. George's Hospital, London. Philadelphia and London: W. B. Saunders and Co. 1905.

Medical News.

A Somerset Medical Officer's Curious Claim.

THERE recently died in Yeovil Workhouse an old woman who for two years had lived in that institution as a "paying guest," the Guardians receiving a considerable sum weekly for maintenance and attendance. At her death her property, which included about £400 invested in Consols, passed to her husband. The workhouse medical officer has now entered with the Guardians a claim for his attendance on the woman whilst in the house on the ground that she was not a pauper, and therefore not entitled to free medical attention during the ten months she was ill. The Board inclined to the doctor's view, and he has been requested to submit a detailed statement of claim.

Society for Relief of Widows and Orphans of Medical Men

AT the annual general meeting of this Society, held on the 22nd inst., Mr. Christopher Heath, the President, in the chair, the report for 1904, which was read and adopted showed that during the year nine new members were elected, five members died, and five resigned. At the end of the year there were 149 life members and 144 subscribers. Two widows were elected and three widows died, there being 52 in receipt of pensions at the end of the year. Two orphans were elected and one became ineligible, leaving 16 in receipt of pensions. Regret was expressed at the death of Mr. J. B. Blackett, M.R.C.S., who had for thirty-seven years ably filled the office of Secretary to the Fund, and the directors announced that they had appointed Mr. Edward Blackett to fill the vacancy until the July Quarterly Court of Directors, at which the Secretary is annually elected. During the year the sum of £3,214 10s. had been distributed amongst the annuitants of the charity. The invested capital of the Society now amounts to £98,810. The advantages of this society cannot be too strongly urged upon the members of the medical profession, especially the younger ones, for it is open to all registered medical practitioners, who at the time of their election are in practice within a radius of twenty miles from Charing Cross. The annual subscription is £2 2s., payable either in one sum or in two half-yearly instalments. Full particulars can be obtained on application to the Secretary, 11, Chandos Street, Cavendish Square, London, W.

Royal Army Medical Corps.

MAJOR F. J. WADE-BROWN, from Gosport, and Captain H. O. B. Browne-Mason, from India, are appointed to the London District for duty, and Lieutenant-Colonel F. J. Lambkin is appointed for duty to the London Military District. Major McCormack, retired pay, assumes medical charge of troops and Military Hospital, Omagh. Colonel R. H. Quill, who has been promoted to Surgeon-General, is appointed Principal Medical Officer at Netley.

Royal College of Surgeons in Ireland Fellowship Examination.

THE following candidates having passed the necessary examination have been admitted Fellows of the College: C. A. K. Ball, B.Ch., etc., Univ. Dublin; J. J. Bell, L.R.C.S., etc., Edin.; J. S. Dunne, L.R.C.S.L., &c.; P. H. Falkner, L.R.C.S.I., &c., Captain R.A.M.C.; W. H. Hornibrook, L.R.C.S.I., &c., J. P. Marnell, L.R.C.S.I., T. J. Nicholl, L.R.C.S.I., etc., J. P. Ziervogel, L.R.C.S.I., etc. The following have passed the primary part of the Fellowship examination:—J. M. Alcorn, student, R.C.P. and S.I.; C. M. Benson, B.Ch., etc., Univ. Dublin; J. B. Butler, student, Royal Univ. Ireland; H. M. Johnston, B.Ch., Royal Univ. Ireland; J. M'Namara, student, R.C.P. and S.I.; A. A. Murphy, student, R.C.P. and S.I.

By the will of Miss G. Hatfield, of Sussex Square London, W., which has now been proved, St. Mary's Hospital, Paddington, receives a sum of £250, and the Western General Dispensary, Marylebone, and the Brompton Hospital for Consumption, £100 each.

Notices to Correspondents, Short Letters, &c.

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

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 re-forwarding 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.

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.

L.S.A. (Deptford).—Cerevisine is the name given to a preparation containing the active principle of yeast and introduced for the treatment of furunculosis. Other approved methods are the injection of pure carbolic acid and the use of an anti-coccid vaccine or serum.

THE *Daily Mail* is responsible for the following story of Dr. Osler "Shortly after the cable brought news of the honour conferred upon him in England, a friend met him on the street. 'I see you have been appointed Regius Professor at Oxford. Great honour indeed.' 'Yes,' was the languid reply; 'I suppose the boys will call me "Reggie" when I get there.'"

A SLIGHT MISUNDERSTANDING.

Hospital Physician (with a view to diagnosis): "What do you drink?" New Patient (cheering up at this proposal): "Oh, sir—thank you, sir—whatever you—I leave that to you, sir!"

G.P. (Cape Town).—Two good books are the "Role of Modern Diets in the Causation of Disease," by J. Sim Wallace (Baillière, Tindall & Cox), and "Physiological Economy in Nutrition," by L. H. Chittenden (Heinemann).

DR. F.—Thank you for the offer, but such a paper would only possess the remotest medical interest.

D.P.H. (Saltoote).—The International Conference for the Protection of Workmen which met two weeks ago at Berne, dealt with the important industrial subject of white phosphorus in matches.

DR. K. S.—The Royal Army Medical College is not intended for the education of medical students but will be for the further training of officers already in the service. There have been several misstatements in the press lately about this due possibly to the fact that its original object was the training of medical corps attendants.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MAY 31st.

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY (20 Hanover Square, W.).—5 p.m. General Meeting. Election of President, Officers, and Council for the year commencing October, 1905. 5.30 p.m. Ordinary Meeting. Address:—Dr. W. Murray: The Limitations of Treatment. 7.30 p.m. Annual Dinner at the Criterion Restaurant, followed by a Smoking Concert.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. A. H. Tubby: Clinique. (Surgical.) 5.15 p.m. Dr. G. A. Sutherland: Pneumonia in Children.

THURSDAY, JUNE 1st.

NORTH-EAST LONDON CLINICAL SOCIETY (Tottenham Hospital, N.).—4.30 p.m. Clinical Cases.

RONTGEN SOCIETY (20 Hanover Square, W.).—8.15 p.m. Paper:—Dr. W. Deane Butcher: The Röntgen Congress in Berlin.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Dr. J. Morrison: Some Practical Points concerning the Use of Midwifery Forceps.

FRIDAY, JUNE 2nd.

LARYNGOLOGICAL SOCIETY OF LONDON (20 Hanover Square, W.).—5 p.m. Cases and Specimens will be shown by Dr. St. Clair Thomson, Dr. Waggett, Dr. A. Thorne, Dr. Kelson, Mr. de Santi and others.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. E. Lake: Clinique. (Ear.)

SATURDAY, JUNE 3rd.

OTOLOGICAL SOCIETY OF THE UNITED KINGDOM (Manchester).—10 a.m. Extra-Metropolitan Meeting.

TUESDAY, JUNE 6th.

THE MEDICO-LEGAL SOCIETY (23 Albemarle Street, W.).—8.15 p.m. Discussion: (1) Some Notes upon Suicide—W. Wynn Westcott M.B. (2) Feeling and Emotion in Eastern and Western Psychology: their bearing on Crime and Insanity—Miss Louise (Appel. M.B., B.Sc.

Bacancies.

Grimsby and District Hospital.—Resident House Surgeon. Salary £120 per annum, with board, lodging, and washing. Applications to S. M. Forrester, Secretary.

Nottinghamshire Consumption Sanatorium, Mansfield.—Lady Resident Medical Officer. Salary £100 per annum. Applications to the Clerk, Mr. G. Sheldon, 36a, Bridlesmith Gate, Nottingham. Somerset and Bath Asylum, Wells.—Second Assistant Medical Officer. Salary £130 per annum, with board, lodging, washing and attendance. Applications to the Superintendent.

Southwark Union, London.—Assistant Medical Superintendent of their Infirmary, East Duiwich Grove, S.E. Salary £100 per annum, with furnished apartments, board, and washing. Applications to Howard C. Jones, Clerk, Union Offices, John Street West, Blackfriars, Road, S.E.

Metropolitan Asylums Board.—Male Senior Assistant Medical Officer at the Asylum at Darenth, near Darford, Kent. Salary £250 per annum, with rations, board, lodging, attendance and washing. Applications to the Office of the Board, Embankment, London, E.C.

St. Giles, Camberwell.—Assistant Medical Officer at the Infirmary, Brunswick Square, S.E.—Salary £120 per annum, with apartments, board, and washing. Applications to the Medical Superintendent, at the Infirmary, Brunswick Square, Camberwell.

Appointments.

BRIDGES, E. CHITTSDEE, M.D., B.S. Durh., M.R.C.S. Eng., L.R.C.P. Lond., Honorary Anaesthetist to the Victoria Hospital for Children, Chelsea.

CUNNING, JOSEPH, M.B., B.S. Melb., F.R.C.S. Eng., Assistant Surgeon to the Victoria Hospital for Children, Chelsea.

HEATON, CHARLES, M.D. Brux., M.R.C.S., L.R.C.P., Honorary Assistant Visiting Surgeon to the Royal Sea-Bathing Hospital, Margate.

HILLIS, JOHN D., M.R.C.P.I., Hon. Consulting Physician to the Rathmines and Pembroke Joint Hospital for Infectious Diseases.

HOOPER, GEORGE HENRY JAMES, M.D. Lond., L.R.C.P. Lond., M.R.C.S., J.P., Chairman of the Sutton (Surrey) District Council.

HOOPER, Miss E., M.B., B.S. Lond., Resident Clinical Assistant to the Hospital for Women and Children, Leeds.

LYLE H. WILLOUGHBY, M.B., B.S. Lond., F.R.C.S. Eng., Ophthalmic Surgeon to the Royal Ear, Hospital, Soho, and Consulting Ophthalmic Surgeon to the Beckenham Cottage Hospital.

Births.

McKENZIE.—On May 25th, at Holly Lodge, High Road, Leyton, Stone, the wife of Dan McKenzie, M.D., of a daughter.
BOUNTREE.—On May 25th, at 31, Fellow's Road, Hampstead, the wife of W. A. Bountree, M.B., prematurely, of a son, stillborn.

Marriages.

COOKE—WRIGHTSON.—On May 25th, at the Sunderland Parish Church, Arthur Digby Serrell Cooke, M.B., C.A.B., youngest son of J. E. Cooke, late of the Indian Civil Service, to Beatrice, eldest daughter of Mrs. Wrightson, 3 Avenue Terrace, Sunderland.

Deaths.

BADELEY.—On May 23rd, at Bournemouth, Emily Maria, third daughter of the late John Carr Badeley, M.D., F.R.C.P., of Guy Harlings, Chelmsford.

OPEN AIR and "REST" CURE.—The advertiser wishes to meet with a fully-qualified medical man interested scientifically in above, for cure of gastric and nervous disorders, brain-fag, &c. to co-operate with him on mutual basis in starting private establishment near London (Surrey hills contemplated). Capital not required but utilisable. Must reside or practice near.—Write "E.R.," 44 Chancery Lane, London, W.C.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX"

VOL. CXXX.

WEDNESDAY, JUNE 7, 1905.

No. 23.

Original Communications.

THE MECHANISM OF THE PAIN IN MIGRAINE.

By FRANCIS HARE, M.D.,

Late Consulting Physician to the Brisbane General Hospital; Visiting Physician to the Diamantina Hospital for Chronic Diseases, Brisbane; Inspector-General of Hospitals, Queensland.

In a recent article it was pointed out that a study of the factors concerned in maintaining uniformity of general blood-pressure leads to the inevitable conclusion that areas of vaso-constriction are frequently compensated by areas of vaso-dilation, and conversely; and that the extension of this principle to pathology goes far towards the elucidating and mechanism of numerous morbid affections which at present seem obscure. In that article the principle was applied to the mechanism of the dyspnoea of asthma; in this, it will be applied to the mechanism of the pain of migraine.

The pain of migraine has been ascribed to a tetanus of the sympathetic (Du Bois-Reymond) (1), that is, to a localised vaso-constriction; to a paralysis of the sympathetic (Möllendorff) (2), that is, to a localised vaso-dilation; and to a constriction occurring in the continuity of a dilated artery (Lauder Brunton) (3). I shall attempt to show that the pain of migraine is the true analogue of the dyspnoea of asthma, in that it is caused by a peculiar pathological modification of vaso-motor action, and depends proximately upon vascular distension at the seat of pain, due to a vaso-dilation which is compensatory of, and exaggerated by, widespread peripheral vaso-constriction.

Peripheral Vaso-constriction.—In most cases there is widespread vaso-constriction of the skin during the paroxysm. Anstie says the patient is intensely chilly. "The feet are generally actually, as well as subjectively, cold" (4). Möllendorff noted "the icy coldness of the hands and feet, and shivering of the surface generally" (5). The vaso-constriction may affect the face. In Du Bois-Reymond's case the superficial temporal of the affected side was always constricted; the same is true of the anterior temporal in the case of Lauder Brunton (6). It can hardly be maintained that the vaso-constriction is the proximate cause of the pain, for the extremities, which seem most conspicuously and constantly affected by vaso-constriction, are never painful in migraine.

Localised Vaso-dilation.—Wilks, himself a sufferer, says that "whilst the body is cold the head is hot, and that whilst the radial artery is small, the carotid is full; in fact, if the term, 'determination of blood to the head' is applicable to any malady, it is assuredly to this. . . . The carotid on one side throbs inordinately, is apparently very full, and is sending too much blood to the brain and its coverings" (7). Möllendorff points out that the vaso-dilation may sometimes be seen in the retina. In one case, "during the attacks the background of the eye on the suffering side was of a bright scarlet red, the optic papilla red and

oedematous, the arteria and vena centralis retinae enlarged, the latter knotty and very tortuous (8). He insists upon the fact that "the pain and tension . . . are also felt deeply in the interior of the head in the parts supplied by the internal carotid, and where, from their small extensibility and rigid surroundings, a trifling increase in their fluid contents would be felt as tension" (9).

Cardiac Compensation.—The vaso-constriction and vaso-dilation in migraine may be accurately balanced. In this case there will be no tendency to alteration of the general blood-pressure, and therefore no demand for alteration of cardiac action. Hence, in perhaps the majority of cases the pulse-rate is unaffected.

But vaso-constriction may be in excess. There will then be a tendency to rise of general blood-pressure, and therefore some cardiac inhibition will be demanded. Hence cases occur in which the pulse-rate falls. Möllendorff refers to cases in which, throughout the whole course of the headache, the normal pulse-rate is lowered, sinking, it may be, from 76 to 48 (10). Foster states that in vagus inhibition of the heart the beat may be slowed or weakened, or both; it is never increased in force (11). This accords with my experience in those cases of migraine in which the pulse is slowed. The pulse is often weak; it may be irregular, and in two cases it was regularly intermittent.

It may be, however, that vaso-dilation is in excess. There will then be a tendency to fall of blood-pressure, and therefore some increase of cardiac action will be demanded. Hence cases occur in which the pulse-rate rises. Labarraque describes the pulse as hard and frequent (12). Tissot says it is always hard and quick when the suffering is severe (13).

Mechanism of the Pain.—It seems unnecessary to search further for the mechanism of the pain in migraine. There can be no more certain means of causing vascular distension than widespread vaso-constriction combined with localised vaso-dilation. In this way the blood is in great part shut off from the periphery, and delivered in correspondingly greater quantity and with concentrated force at the site in question. This is what presumably occurs in migraine. The clinical manifestation of the vascular distension will vary with many circumstances. It will vary with the anatomical features of the structure affected. If such structure be a free mucous surface swelling will result; and when such swelling affects the mucosæ of the bronchioles there will be obstructive dyspnoea, as we have seen in asthma (14). But free swelling will preclude nerve-pressure and pain; and pain, as a rule, is lacking in asthma. In migraine, however, it is probable that the structures mainly affected are the scalp, pericranium, and dura-mater; sometimes one, sometimes another, sometimes all three. These structures are highly vascular; they are also inextensible; and the last two are closely adherent to the subjacent bone. Hence vascular distension in these situations will inevitably result in extreme nerve-pressure and pain. And the character of the pain is exactly what would result from vascular distension or active hyperæmia from arterial dilation; it is

distensible and throbbing, and has frequently been likened to the pain of whitlow.

CLINICAL EVIDENCE THAT VASCULAR DISTENSION IS THE PROXIMATE CAUSE OF PAIN.

A part of this may be thus generalised:—Anything which reduces the vascular distension will relieve the pain; anything which increases the vascular distension will increase the pain. The vascular distension may be reduced: (1) By pressure on the arterial trunk supplying the part; (2) by vaso-constriction in the arterioles of the part; (3) by vaso-dilation in the peripheral constricted area, or generally (4) by reduction in the force or frequency of the heart-beat; and (5) by reduction of the amount of blood in circulation. On the other hand, the vascular distension may be increased: (1) By pressure on arterial trunks supplying collateral areas; (2) by increase of vaso-dilation in the arterioles of the part; (3) by increase of vaso-constriction in the peripheral constricted area; (4) by increase in the force or frequency of the heart-beat; and (5) by increase of the amount of blood in circulation.

Pressure on Arterial Trunks Supplying the Part and on Arterial Trunks Supplying Collateral Areas.—Möllendorff, following Parry, says: "If the common carotid artery be forcibly compressed on the painful side at the level of the thyroid cartilage during the hemicranial paroxysm, so that the pulse in the temporal artery begins to fail, the headache vanishes as if by magic. The eye is opened in a lively manner, the oppressed and suffering face brightens up, and seems to inquire, with an expression of delight, 'What has become of the pain?' Unfortunately, however, with the intermission of the compression, with the first full pulse-wave, the pain begins afresh. . . . This experiment has infallibly succeeded with me in the case of all persons suffering from hemicrania whom I have had the opportunity of seeing in the attack (15)."

I have made the following series of observations on the effects of compressing arteries during migraine paroxysms:—(1) In unilateral migraine pressure on the common carotid of the correspondingside invariably, immediately, and completely removes all pain; while pressure on the common carotid of the opposite side increases the pain. (2) In bilateral migraine, pressure on either common carotid removes the pain on the corresponding side and increases the pain on the opposite side; by alternately compressing the right and left common carotid the pain may be rendered hemicranial on the left and right side alternately. I have not tried simultaneous compression of both common carotids. (3) In a case of bilateral occipital migraine, immediate relief followed compression of both occipital arteries; the pain was rendered unilateral by compression of one occipital. (4) In a case of intense pan-cranial migraine complete cessation of all pain followed simultaneous compression of both temporals and both occipitals; the pain was rendered unilateral by simultaneous pressure on the temporal and occipital of one side, or by pressure on one common carotid. It became limited to the posterior portion of the cranium by pressure on both temporals, and to the anterior portion of the cranium by pressure on both occipitals; finally, pressure on any one of the arteries named relieved the pain in the area of distribution of that artery. (5) In a case of severe frontal bilateral migraine the patient discovered for herself that pressure on both angular arteries, which always throbbed violently, gave great though not complete relief; and she had thought of devising a special padded clip for use during attacks. (6) In cases associated with dilation of the temporal on the affected side, pressure on this vessel affords relief, which, however, may be complete or incomplete. When incomplete we may assume that the temporal does not supply the whole of the dilated area. (7) In cases associated with constriction of the temporal on the affected side, pressure on this vessel affords no relief; it may add to the pain. Here we may assume that the dilated area lies within the distribution of some artery which arises behind the superficial temporal; for example, the internal maxillary, the occipital, or the internal carotid. This assumption would fit such cases as Du Bois-Rey-

mond's, in which the skin of the face remained pale and cold throughout the attack, and regained its normal colour and temperature only when the pain abated (16). (8) In many cases general compression of the painful area of the scalp gave much relief: this has been noted by many writers; cases so relieved must, of course, be largely extra-cranial.

Vaso-constriction in Arterioles of the Part.—As is well known, the application of cold lotions or ice to the scalp sometimes affords great relief. When this occurs the area of vascular distension is doubtless mainly extra-cranial, and the relief afforded is through vaso-constriction of the arterioles of the part, just as is the relief from the dyspnoea of asthma through inhalation of cold air (17). But the practice of applying cold in such cases cannot be regarded as free from all danger. Lauder Brunton points out that "the pain may leave the head altogether quite suddenly and commence in the abdomen (18). And there seems no doubt that such a sudden metastasis may be precipitated by cold applications. "A young man . . . was seized . . . with darting pains in the right temple which soon spread to the opposite side. One evening, while his face was red, cold compresses were applied to the forehead; in the course of a few minutes the pain in the head had abated, and at the expiration of three or four more minutes entirely disappeared. At the same time a sense of oppression was felt in the epigastrium; then suddenly, agonising pains set in in the same region, accompanied with a sense of suffocation, painful efforts to vomit, and the escape of gas from time to time from the mouth" (Valleix) (19). Very similar metastases may occur in acute articular gout, and are often due to the same interesting factor, namely, cold to the hyperæmic part.

Increased Vaso-dilation in Arterioles of the Part.—Cases are to be found in which hot applications to the scalp materially increase the pain. In such the area of vascular distension is doubtless mainly extra-cranial; and the increase of pain is strictly analogous to the increase of dyspnoea which follows inhalation of warm air in asthma (20).

Vaso-dilation in the Peripheral Constricted Area, or generally.—This in the great majority of cases affords distinct immediate relief from the pain of migraine, as it does from the dyspnoea of asthma (21).

The periphery may be dilated in many ways. "Une vive stimulation des pieds par l'eau chaude ou par la proximité d'un brasier, a quelquefois arrêté brusquement la migraine" (Piorry) (22). Graves successfully prescribed immersion of "the legs as far as the knees in hot water" (23) for the headaches of young women. Haig obtained relief by sitting over a fire. Hot immersion of the arms gives ease. A full-length hot bath is still more efficient. But all these means of relief have a mere temporary influence.

Dry-cupping is useful. Sipping very hot water may give ease. Part of the relief from headache which follows a cup of tea depends on the heat, for cold tea is much less efficient.

The nitrites are efficient dilators of the periphery. Lauder Brunton has "employed the nitrite of amyl in headache, and found that frequently though not invariably, it relieved the pain" (24). Gowers finds nitro-glycerine the most generally useful drug in migraine (25).

Leonard Hill has shown that violent exercise temporarily raises the blood-pressure by about 20 mm.; "this lasts for about fifteen minutes, and is then followed by a fall" (26). The fall is comparatively enduring, and is doubtless in great part due to extensive vaso-dilation, muscular and cutaneous. The influence of exercise upon migraine and upon many less typical forms of headache runs parallel with its influence upon blood-pressure, just as does the influence of exercise upon the asthmatic dyspnoea (a).

Exercise during paroxysms causes at first an increase of dyspnoea and an increase of pain respectively. But exercise steadily persisted in is capable of abbreviating

(a) The influence of exercise and pyrexia upon the asthmatic dyspnoea was inadvertently omitted from the article on "The Mechanism of Asthma" in the MEDICAL PRESS AND CIRCULAR for April 19th.

the asthmatic dyspnoea (Hyde Salter) (27) and many forms of headache, including that of migraine (Parry) (28).

Broadbent points out that "arterial relaxation is the condition of the vessels characteristic of pyrexia (29). Hence migraine, as well as asthma (a), will be found, as a general rule, to remain in complete abeyance during pyrexia. But just as there is an exception to the rule that vascular relaxation is characteristic of pyrexia, so there is an exception to the rule that migraine and asthma remain in abeyance during pyrexia. For in pyrexia associated with cutaneous vaso-constriction, manifesting itself in rigor or even in chilliness and tendency to shiver, the paroxysms of both neuroses are apt to be precipitated. The invasion stage of almost any pyrexia, and the recurring cold stages of malaria, are frequently complicated by migraine (MacCulloch) (30) and asthma (Charles Morehead) (31), in those predisposed to these neuroses, and even in others.

Increase of Vaso-constriction at the Periphery.—This will tend to precipitate migraine paroxysms or to intensify the pain of existing attacks. Exposure to cold has often precipitated an impending migraine: and cold air, bathing, and cold applications, except when applied directly to the dilated area, intensify the suffering during attacks. All such are instinctively avoided by patients. The headaches, which Symonds says are due to ice in the stomach, are similarly explicable (32).

Even in persons not disposed to migraine, severe headaches may be induced by sudden vaso-constriction of some extensive area. In applying the cold bath in typhoid fever, very severe headache may be caused if the body is immersed without previously cooling the head and neck (33); and the same may happen in healthy persons from jumping into deep water feet foremost.

Reduction in the Force or Frequency of the Heart-beat.—This may give much relief. The onset of vomiting or even of nausea is often the signal for the abatement of pain (34); and both conditions are associated with reduction of systolic force. Severe migraine may be complicated by faintness, even syncope. Such always bring relief; and Parry regarded the cardiac weakness in such cases as conservative (35). Probably the relief which follows the use of antipyrin and many other drugs of the same class depends in great part upon reduction of systolic force.

Increase in the Force or Frequency of the Heart-beat.—This will naturally intensify the pain. Ammonia and alcohol may have this effect. But alcohol has a twofold influence upon the circulatory system. It increases the force of the heart, but tends also to cause peripheral vaso-dilation; and it may produce these two effects in different degrees in different persons. Hence probably, the seemingly inconsistent observations that alcohol may relieve or increase headache. As Liveing says, it is impossible to "deny the rapid dispersion of an attack which occasionally follows a glass or two of wine or other stimulants" (36). But it is equally impossible to deny that in many cases an exacerbation of pain succeeds.

Reduction of the Amount of Blood in Circulation.—Hæmorrhage of any kind affords immediate relief; the effect is most rapid when the blood comes from the distended area. Epistaxis (37), hæmorrhoidal hæmorrhage, venesection (38), the establishment of free menstruation (39), may all terminate migraine temporarily.

Increase of the Amount of Blood in Circulation.—The influence of this upon the actual paroxysm can hardly be demonstrated. But I have seen a case (not anæmic at any time) who became worse as he became "plethoric."

The priority over the pain of vascular distension due to vaso-motor action is further attested by the not infrequent occurrence of hæmorrhage and œdema at the seat of pain. Liveing refers to sudden choroidal hæmorrhage (40); Gowers to œdema and even "ecchymoses at the seat of the most intense pain (41); Tissot to "an extravasation of blood, rendering the skin

of the forehead, eyelids, and even cheeks, black and blue" (42); Labarraque to ecchymoses of the conjunctivæ (43), and Hilton Fagge to the case of Dr. J. Phillips, in whom a fatal attack of apoplexy occurred during the course of a headache indistinguishable from migraine (44). Lauder Brunton, too, draws attention to the fact that ocular tension may be increased during the headache of so-called biliousness (Harry Campbell) (45); and acute double glaucoma (46) has occurred during an attack of migraine, which affection had been previously recurrent. It is easy to see that dilation of the arteria centralis retinæ might determine this accident in an eye anatomically predisposed by hypermetropia.

The evidence that the pain of migraine is due to vaso-motor action seems sufficient; and it is so highly probable that the other sensory symptoms sometimes regarded as migrainous auræ own a similar mechanism. Lauder Brunton takes this view. He says: "The pain of migraine is frequently accompanied by other phenomena which are really explicable on the hypothesis that those branches of the carotid artery which pass to the interior of the skull are affected in the same way as those which pass to its outside. If the terminal branches of the temporo-sphenoidal artery become contracted like a bit of piano wire, as the one which runs up my forehead does during a headache, the nutrition of the centre for sight in the brain must necessarily be impaired, and if the spasm should extend farther down the artery, the centres for hearing, taste, and smell will also suffer. I think it is probable that such impairment is the cause of the indistinct vision of the hemianopia—i.e., blindness to all subjects on one side of the body, either to right or left, even of complete blindness, and of the zigzags which occur either before or during an attack of migraine. The senses of taste and smell are less frequently affected, but I have one case in which the patient has neither taste nor smell during the attack of headache, and after it is over both taste and smell return quite suddenly. . . . In other cases one finds aphasia present to a greater or less extent during the attack, passing off when it is over" (47).

Gowers, after pointing out that the vascular disturbance in the brain may lead at times to vascular degeneration, says: "Hemianopia habitually preceded the headaches in a woman who, after reaching the degenerative period, found one day that the hemianopia persisted after the pain. It was permanent, and due, as was subsequently ascertained, to a lesion in the opposite cuneus (48). Such an accident is strong evidence in favour of the priority of vaso-motor action. For, if the permanent hemianopia was caused by the permanent vascular lesion, then it seems more than probable that the temporary hemianopia depended upon the temporary vascular changes due to vaso-motor action.

I shall argue later that the pathological variation of vaso-motor action, which constitutes the migraine paroxysm depends upon a "humoral factor" common to many neuroses; and that the marked tendency to periodicity of this affection depends on accumulation of this humoral factor during the intervals—which accumulation is discharged or got rid of at each paroxysm.

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COLLES'S FRACTURE

AND OTHER FRACTURES AND DISJUNCTIONS AT THE LOWER END OF THE RADIUS AND ULNA.

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(Concluded from page 558.)

I. CASES in which the dorsal displacement is by far the most marked feature.

In one of my skiagraphs, taken antero-posteriorly, there is not the slightest trace of radial displacement, and one would hardly be prepared for the appearance presented by the skiagraph taken from side to side. The lower end of the radius seems simply to have been rotated backwards on its transverse axis without lateral displacement (Fig. 4). This is the type of the first form. Many of the skiagraphs in my possession conform more or less closely with this type. The ulnar styloid may or may not be torn off. The deformity present in these cases is chiefly antero-posterior. There is a dorsal swelling proximal to the wrist on the radial side so that the hand appears to be lengthened (Fig. 13A). Corresponding to this there is a hollow on the anterior surface limited above by a

projection corresponding to the lower extremity of the upper fragment. This is called the silver fork deformity. The styloid process of the radius is on a level with or even higher than the head of the ulna, which projects unduly on the inner side and in front. Laterally, a ridge is often felt corresponding to the upper margin of the lower fragment of the radius. The shortening of the radius is due to the backward displacement. The hand is in most cases either normal or somewhat adducted (see skiagraphs), due to a rolling of the carpus on the articular surface of the radius. It is remarkable that almost all writers on Colles's fracture state that the hand is abducted. If by abduction is meant flexion to the radial side it is most unquestionably absent in the large majority of cases.

I have not noticed in any of my cases any appreciable narrowing of the interosseous space, which has been supposed to be produced by the action of the pronator quadratus on the upper fragment. Hamilton (1) says "any considerable degree of displacement in this direction is a rare event." I have, however, one or two skiagraphs in which the space is actually widened; in one case it is due to comminution of the lower fragment (Fig. 6), and in others to complete separation of the lower end of the radius from the ulna.

II. In the second class of cases the displacement is principally to the radial side, with or without accompanying dorsal displacement (Fig. 7). These cases I believe to be caused by a fall on the ulnar border of the hand rather than by a fall on the palm. The lower end of the radius and frequently the styloid process of the ulna are broken off and displaced to the radial side. The lower fragment of the radius is rotated on the antero-posterior axis previously mentioned, and may actually look outward. It carries the axis of the hand with it to a considerable extent, and produces marked deformity. The ulna projects on the inner side more than in the variety I have just described, and gives rise to a very ugly deformity if treatment be unsuccessful, as it too often is. Even in these cases I have frequently found the fingers adducted, but true abduction does sometimes occur in this class. Broadening of the wrist is a marked feature in these cases.

III. In the third class, of which I have only had one example, the lower fragment is displaced forwards. The fracture is produced by falling on the back of the hand and is called a reversed Colles's. In my case, a male, *æt.* 50, the cause was a fall on the back of the hand. The line of fracture was oblique, and extended from about an inch above the tip of the styloid process to the articular surface for the head of the ulna. The ulna was not fractured. There was considerable radial displacement of the lower fragment, which was completely separated from the ulna. The hand was radially displaced, the ulna prominent, and the fingers straight (neither adducted nor abducted). The extensor tendons were stretched across a hollow space corresponding to the displaced lower fragment, and there was great increase in the antero-posterior diameter of the limb above the wrist. The condition was not recognised until the fragments had set in their new position. Crepitus is reported to have been present when the case was first seen. The patient recovered with a useful hand. Speaking of the forward displacement, Smith (2) says, "this is an injury of exceedingly rare occurrence, and one which presents characters closely resembling those of dislocation of the carpus forwards." Gordon mentions this form of fracture, and states that it is very rare and that he has not met with it in the living subject.

Under these three heads most of the displacements with which I am familiar can be classified. I have already referred to several cases in which the fracture took off the styloid process of the radius and involved the joint. Other forms of fracture occur but they are very rare.

Complications.—I have incidentally mentioned some of the complications commonly met with.

1. Fracture of the lower end of the ulna, already described in three of the series.

2. Fracture of the styloid process of the ulna, which occurred in 52 per cent. of my cases.

3. Impaction, which was well marked in 12 cases out of 45.

4. Comminution, which was present in five cases.

5. Rupture of the triangular fibro-cartilage, allowing of separation of the radius and ulna, and causing broadening just above the joint. I have seen this separation take place without fracture of the styloid process of the ulna.

6. Injury to the median nerve, causing temporary numbness and tingling in its area of distribution—produced by the sharp edge of the upper fragment—occurred in two cases.

7. In one case a unique complication occurred—namely, laceration of the tendon of the extensor secundi internodii pollicis with loss of power of extension of the second phalanx of the thumb. This occurred in an old woman and was not noticed until she began to use her hand after the accident. It was probably produced by the sharp edge of the lower fragment. Four months later she allowed me to operate. I sutured the distal portion to the extensor primi tendon, with satisfactory results.

8. Fracture of the anatomical neck of the humerus on the same side occurred in one case, that of a woman, *æt.* 55.

9. Dislocation of both bones backward at the elbow-joint occurred in the practice of a medical friend, who kindly presented me with a skiagraph of the case.

10. I have not seen the fracture compound, but such a complication may very readily occur. It is more frequent in disjunction.

11. Fracture of the carpal bones. In one case fracture of the scaphoid occurred with dislocation backwards of the whole bone. The case is included in the present series because of the fracture of the posterior margin of the articular surface of the radius, which, I believe, was present. I showed the scaphoid removed at a meeting of the Ulster Medical Society. The patient was a male over 50 years of age.

Treatment.—So many different methods of treating these fractures have been suggested from time to time that it would take too long to describe them. I shall content myself with describing the treatment I myself adopt, commenting shortly on those that seem to me to be erroneous in principle. The New Sydenham Society's Atlas of Pathology for 1904, already several times referred to, contains the following remarkable statement: "One fact is considered by those who discard all splints and make no efforts at reduction to be established beyond controversy. It is that no sort of disability results from this negative practice. They assert strongly that the injured hand is fit for use again in a much shorter time than if splints had been applied; that little or no subsequent treatment by massage or other expedients is usually required to restore free motion, and that ultimate usefulness of the hand is just as good as its fellow. A certain amount of unavoidable deformity is, they assert, the only drawback to their practice. All that is needful is to prepare the patient's mind for this, and then but little disappointment will result."

If this is the newest treatment of Colles's fracture I protest against it in the most emphatic manner possible. In this city we can show scores of cases where treatment has reduced the deformity almost if not completely, and where the use of the hand has been restored in one month. I have frequently exhibited, to students of my class in the out-patient department, cases in which after a fortnight in splints and a week's movement the hand is almost if not quite as good as its fellow, even when impaction has occurred. To reduce the dorsal deformity the patient's hand is flexed over the surgeon's knee so as to undo the rotation of the lower fragment on its transverse axis. But this is not enough, as can be seen by skiagraphs. It is necessary by firm pressure with the thumbs to drive the lower fragment forwards while the hand is flexed; otherwise the broken surfaces may be in contact in part only of their extent. Surgical extension may be tried while the fragment is being

forced into position. For these manipulations I have found anæsthesia by ethyl chloride of the utmost value; in most cases it gives the necessary relaxation, besides being, with reasonable care, quite safe. If there be much impaction the hand should be hyperextended, hyperflexed, and laterally moved by turns until the fragments are loose, care being taken to avoid unnecessary damage. I have very little faith, however, in the lateral movements, either to reduce the deformity or to keep it reduced. The carpus rolls on the articular surface of the radius and very little purchase can be obtained. Pressure with the thumbs may be tried to force the fragment towards the ulna in the radial displacement form and will succeed in some instances. The second indication is to keep the fragments in position. For those fractures in which the dorsal displacement is the predominant feature I use two splints (Fig. 13B). The anterior splint comes down as far as the fracture, but must not impinge on the prominent anterior border of the lower end of the distal fragment. The posterior splint is applied after the manner of Roser as figured in Helferich (3), with the exception that the hand is prone instead of supine as in his method. The splint extends to the first row of phalanges and is so padded at its anterior end that it causes the hand to be flexed to an angle of about 45°. Flexion of the hand, I believe, lies at the root of success in the treatment of these cases. The pad over the dorsum of the hand is large and wedge-shaped. Straps and buckles and a bandage complete the dressing, and the limb is carried in a sling supporting the hand as well. By this method I have had such excellent results that I do not feel disposed to use any other.

For those cases in which displacement to the radial side is the prominent feature, I fail to see how dorsal and palmar splints are to effect any improvement (see Figs. 7 and 14A). The forearm is broad already, and any further pressure antero-posteriorly will tend to increase the deformity. I believe there is only one way to keep the displacement within bounds, and that is by lateral pressure. No ulnar flexion of the hand can drag the fragment into place. It must be pushed into position and kept there by a retentive apparatus. This can be done by a Gordon's splint or by a very simple splint which I have had made for the purpose. The latter (Fig. 14B) consists simply of a piece of wood broader above than below, and hollowed out to fit the convexity of the forearm and hand on the ulnar side. The distal end which fits the ulnar border of the hand to beyond the middle of the metacarpus is inclined at a slight angle to the rest of the splint, so that the hand may not be unduly pushed over into the position of abduction. A hole may be cut in the splint at the position of the ulnar head to avoid painful pressure. When in position the hand is neither abducted nor adducted; the splint is rather wider than the limb, so as to allow for blood and lymph circulation when it is in position. It is bound to the forearm (Fig. 14C) at its upper part by adhesive strapping, to prevent it from turning round the limb. A pad is then applied over the radial fragment, and pressure is exerted on it by a strap and buckle which passes over the lower portion of the splint; the latter should be well padded with cotton wool on which boracic acid has been dusted. By means of this splint and pad it is hoped to approximate the laterally displaced radial fragment to the ulna, and so reduce or obliterate the most unsightly deformity which characterises this class of case. The splint may be applied on the *radial* side of the hand and forearm, and the lower fragment thus pushed over into position, but I prefer the former method. If some dorsal deformity tends to persist after reduction, antero-posterior splints may also be applied with a pad over the dorsal projection. The "atelle cubitale," or ulnar splint, was used by Dupuytren, Chelius, and others, but differs from that now described in being made so as to draw the *hand* forcibly to the ulnar side.

Gordon's splint is a useful and often very efficient apparatus for Colles's fracture, but it must be made in a large number of sizes to fit the various limbs requiring it. It is too expensive for hospital patients and is

rather complicated. If simple anterior and posterior splints are used the former must not come down too low lest the projecting anterior border of the radius be pressed on. This would prevent complete reduction. Carr's splint is in frequent use at some hospitals, and is well spoken of. It places the hand in a position of adduction, in the hope of dragging the radial fragment into position. I cannot satisfy myself that it has any special advantages. The pistol splint of Erichsen is obsolete in this school. Gordon (4) states that "the effect of adduction in the treatment of fractures of the lower end of the radius is to produce displacement outwards and upwards of the lower fragment—the most marked deformity of the accident."

I have seen the results of treatment by simple strapping, and have a skiagraph of a case treated by this method, also one of the same case after being treated by manipulation and splints for a fortnight. The difference is greatly in favour of the latter method. Levis's metal radius splint, which keeps the hand flexed at an angle of about 45° may be used for the dorsal form of displacement. Nélaton's apparatus is simply an anterior and a posterior splint, with padding to press the lower fragment forward and the upper fragment backward. Whatever splint is applied it should not be kept on longer than a fortnight or at most three weeks. The fingers should be kept moving throughout the treatment.

To obviate increase of displacement which may take place from softening of the bones during the healing process, the splints might, perhaps, be put on at night, and taken off during the day for a little longer than the prescribed fortnight of continuous splint treatment. A case which looks well immediately after the splints have been removed will often show some deformity six months later. This is due to absorption of the injured and softened bone.

If the treatment I have suggested be carried out, that stiffness which is said to persist for weeks or even months after union will be rarely encountered. It is due in most cases to the long application of splints interfering with the circulation and the movements of the joints and tendons. It may, however, occur as the result of fissures into the joint, or from fracture of the scaphoid or other carpal bone.

Hamilton (5) points out that "there remains, for a long time in many cases, a broad, firm, uniform swelling on the palmar surface of the forearm, commencing near the upper margin of the annular ligament and extending upwards two inches or more. This swelling continues much longer in old and feeble persons than in the young and vigorous." He also says, "there can be no doubt that this phenomenon is due to effusions along the sheaths of the tendons and in the areolar tissue external to the sheaths, and it is as often present after sprains and other severe injuries about this part as in fractures. A similar effusion, but less in amount, is frequently seen also on the back of the hand, below the annular ligament." I have several times been deceived by these swellings into the belief that the bones had become displaced, until satisfied to the contrary by examination. Early massage will do much to prevent or relieve this condition. The inferior radio-ular joint—which is damaged much more frequently than I could have had any idea of prior to the use of skiagraphy—must be carefully attended to, in view of the possibility of stiffness and restriction of the movements of pronation and supination ensuing. Although I have not had the opportunity of dissecting a case with complete separation of the radius and ulna at the radio-ular joint, I feel disposed to think that one of the obstacles to complete reduction may be the interposition of the ruptured triangular fibro-cartilage between the lower ends of these bones. The treatment of the forward displacement will suggest itself. Smith states that the deformity is easily removed and is liable to recur when the extending force ceases to act. Therefore, properly padded anterior and posterior splints keeping the hand in a line with the forearm will be all that is requisite. The after treatment is the same as in the varieties just mentioned.

Colles's fractures that have united with marked and unsightly deformity may possibly be improved by osteotomy, but of this method of treatment I have had no experience.

DISJUNCTION OF THE LOWER EPIPHYSIS OF THE RADIUS.

A few words on the 11 cases of disjunction of the lower epiphysis of the radius. Although Colles's fracture occurs in young people, as verified by skiagraphy yet our experience at the Royal Victoria Hospital is that disjunction of the lower epiphysis of the radius is much more common. In the present series there are only 3 Colles's to 11 disjunctions.

Sex and Age.—All my cases of Colles's fracture under 30 (four in number) were in males, and all the cases of disjunction were in males. Mr. Poland, to whom I had the honour of acting as house-surgeon 14 years ago, in his excellent work on this subject (6) has collected a series of 89 cases in which the sex and age are mentioned. No less than 79 of these occurred in boys, only 10 occurring in girls. No doubt the climbing propensities of the former are responsible for the greater frequency of the accident in them. He gives the most usual age as 12 to 18 years.

My cases were aged as follows: One at 7 years, one at 8 years, three at 9 years, one at 10 years, one at 14 years, one at 15 years, one at 16, one at 17, and one at 18 years. The youngest therefore was 7 and the oldest 18 years.

Causation.—The cause is usually indirect violence, such as falling from a height on the outstretched hand. One of my cases, a boy, *æt.* 10, fell from a loft and had disjunction of the radial epiphyses of both sides. Poland says, "This lesion, like Colles's fracture, may be brought about as mentioned by Malgaigne, by backward over-extension of the hand," that is, by "cross strain." He also states that it may occur, but not frequently, by direct violence. The sharp anterior edge of the lower end of the diaphysis is liable to come through the skin, rendering the disjunction compound. In one of my cases it projected very markedly just under the integument, but the skin fortunately remained unbroken. Fracture of the styloid process of the ulna is mentioned by writers as a frequent complication. In five of my cases skiagraphs were taken, and in one only was this evident—that of a boy, *æt.* 17; in his case the tip was torn off (Fig. 12). In patients under 13 or 14 the process is so cartilaginous that a fracture may exist without being detected by the X-rays.

Poland states that the lower epiphysis of the ulna is rarely detached; he quotes, however, several examples of this complication published by other surgeons. In one of my cases, a boy, *æt.* 16, the ulnar epiphysis as well as the radial was detached, and there was slight displacement of both to the ulnar side as well as backwards. A skiagraph showed the lateral displacement very well. I am inclined to think that, while marked detachment of the ulnar head is perhaps not frequent, there may be some loosening caused by the accident, and I am led to this opinion by observing that a few days after the accident not only is the radial epiphysis swollen but the ulnar is also frequently swollen and tender. This swelling, is, I take it, due to two causes (1) a traumatic epiphysitis, and (2) a stripping up of the periosteum from the diaphysis, to which it is less firmly attached than it is to the epiphysis. Displacement backwards is, as might be expected, the most frequent deformity and it was present in all my cases. In a skiagraph taken immediately after the accident in one of these (a boy, *æt.* 9), the epiphysis of the radius was so much displaced backwards that it appeared to lie on the dorsal edge of the lower end of the diaphysis. The epiphysis was not rotated. In these cases, as Poland says, "there is no rotation or tilting of the epiphysis on a transverse axis; therefore there is no radial inclination or obliquity of the hand." With this exception, the deformity is that of the posterior displacement variety of fracture of the lower end of the radius.

The treatment is simple. The patient is preferably

anæsthetised with ethyl chloride, or other suitable anæsthetic, and the fragments very carefully forced back into position. On account of the slightly cupped surface of the epiphysis and the rounded shape of the end of the diaphysis, there is little tendency to re-displacement. Besides, the surfaces are more transverse than is the case in Colles's fracture. An anterior splint for about ten days is all that is necessary. Healing readily takes place and, so far as my experience goes, permanent deformity is exceptional. On this point R. W. Smith (7) says: "Compared with Colles's fracture there is but little difficulty in the treatment of this accident, nor need any apprehension be entertained of permanent deformity resulting, or of any lasting impairment of the functions of the limb." Poland gives a table of a series of cases of arrested development of the radius after epiphyseal injury, but states that in his own cases there was no arrest of growth in any. He states that "the deformity and attendant inconveniences from arrest of growth increase in proportion to the age of the patient, and the time which has elapsed from the date of the accident," and also that "although the radius lengthens principally by its lower extremity, it is less dependent for its growth on the lower epiphysis than is the ulna." Kirmisson (8) in a recent publication is "of opinion, that, notwithstanding the contrary results of experimental research, shortening of the injured limb has been rarely noted in actual practice after traumatic separation of an epiphysis in the human subject."

REFERENCES.

- (1) "Fractures and Dislocations," p. 307.
- (2) *Loc. cit.*
- (3) New Sydenham Soc., vol. clxvii., p. 102.
- "On Fractures and Dislocations."
- (4) *Loc. cit.*, p. 19.
- (5) *Loc. cit.*, p. 317.
- (6) "Traumatic Separation of Epiphysis," p. 481, *et seq.*
- (7) *Dub. Hosp. Gazette*, 1860, p. 49.
- (8) *Rev. d'Orthop.*, No. 6, 1904, quoted in *Epitome B.M.J.*, Dec. 24th, 1904.

THE PREVALENCE OF ADENOIDS IN COUNTRY DISTRICTS. (a)

By GRIFFITH C. WILKIN, L.R.C.P.LOND., M.R.C.S.,

Late Surgeon to the London Throat Hospital.

In considering the question of the prevalence of adenoids in the child life of the country and the advisability of an expert Committee being formed to investigate the question, I regret that I am unable to give you any trustworthy statistics. But this fact makes the need of the Committee the more self-evident, for when a man is busy with general work he rarely keeps notes of the minor cases, and though, from the point of national stamina, post-nasal growths and tonsils are most important, still, from a surgical point of view the operation for their removal can only be classified as minor. My experience may be put down as of four English counties—Sussex, Somerset, Northampton and Devon, and I have no hesitation in saying that in the country parts of these counties the growths are unduly prevalent. Both in Somerset and Northampton I did much throat work, and in both places my example was followed by other doctors. Anyone who reads the medical papers can easily satisfy himself that ear trouble is fairly prevalent all over the country, and I do not fear any serious opposition when I say that the major-

ity of ear troubles in children arise from post-nasal causes, and that the chief of all these, by an enormous majority, is adenoid growths, accompanied often with enlarged tonsils. I am aware that ridicule is being brought forward as an argument against my pleading. Gentlemen, in my mind this is the highest compliment that could be paid; through ridicule and contempt everything that is worthy seems fated to pass at one time or another.

I would suggest the advisability of this society approaching the Ophthalmological Society of the United Kingdom, the Otological Society of the United Kingdom, and the Laryngological Society of London. If these societies combine with the British Laryngological and Rhinological, a powerful Committee can easily be formed. It appears to be a largely prevalent and accepted idea that the chief use of medicine is the treatment of disease. I beg to differ from that. In my opinion the chief reason for the existence of the medical profession is for the prevention of disease and the guidance of the nation in the most healthy path. Since the above passage was written, I have had the opportunity of reading the able Inaugural Address of our President. In the fifth paragraph of that address he quoted the words of our first President, Sir Morell Mackenzie: "Those who are content perseveringly to interrogate Nature in her everyday dress will, I am persuaded, be fully compensated for such courageous humility. Work steadfastly, then, whether the subject be recondite or apparently trivial. Observe and test everything and bring your results here to be criticised by your fellow workers."

I ask the Society to pass the following resolution:—

"That in the opinion of this meeting it is desirable to appoint a Committee to investigate thoroughly the question of the prevalence of adenoids in the child-life of the country, and its importance on the national stamina."

Clinical Records.

WEST LONDON HOSPITAL.

A Case of Double Iridectomy for Subacute Glaucoma following Ovariectomy.

By PERCY DUNN, F.R.C.S.,
Ophthalmic Surgeon to the West London Hospital.

THE following case seems worthy of record by reason of the fact that it illustrates several points of interest.

On April 25th, 1904, E. R., a single woman, æt. 57, was admitted under Mr. Bidwell, complaining of swelling of the abdomen. Since October, 1903, she had noticed that her abdomen was swollen. In January, 1904, this swelling had become much larger; and, in addition, she was troubled with incontinence of urine. Beyond suffering from gastric ulcer and anæmia in former years, she had always enjoyed very good health. The menopause occurred at 50. The heart and the lungs were healthy; the abdomen was distended in the lower part, while a rounded tumour could be felt rising out of the pelvis. It was dull to percussion, and extended about two inches above the umbilicus. A fluid thrill could be obtained. *Per vaginam* the uterus was movable. Bimanual examination showed that the tumour was fixed to the uterus, apparently on the right side. The urine was acid; specific gravity, 1020. The following note has been kindly furnished by Mr. Bidwell:—

"On April 28th, 1904, Mr. Bidwell opened the abdomen by an incision three inches in length to the

(a) Read at the Meeting of the British Laryngological, Rhinological, and Otological Association, London, May 12th, 1905.

right of the linea alba. The abdomen contained a large cyst connected with the right ovary. The cyst was tapped and removed, after ligature of its pedicle. The left ovary was examined and found to be healthy, and so was not interfered with. The abdominal wall was closed by three layers of interrupted sutures. The patient made an uninterrupted recovery. The wound was dressed for the first time on May 7th, when it was found to have healed; the stitches were accordingly removed."

I am indebted to my former house-surgeon, Mr. A. S. Millard, for the following notes:—

May 2nd.—The patient was seen by Mr. Dunn to-day, as she has been complaining of pain and failing vision in her left eye. The left pupil was widely dilated, oval in shape, and immovable. The eyeball was somewhat injected. The tension was + 2. Sulphate of eserine drops and Chinosol fomentations were ordered every four hours.

3rd.—Injection less and vision improved; can now make out the outline of the ward windows opposite, and can count fingers.

4th.—Improvement continuing.

8th.—Not so well.

9th.—A large upward iridectomy was done under chloroform. The section was made with a Graefe's knife.

10th.—The left eye was dressed, the conjunctival sac washed out with Chinosol lotion (1—4,000). No pain.

14th.—The sight in the right eye is becoming misty, and there is some pain.

15th.—The tension is now + 2, and the vision is worse.

16th.—The vision now amounts only to counting fingers close to the eye. A large upward iridectomy was done to-day, identical with that on the other eye.

25th.—Vision much improved in each eye. Both eyes doing well.

26th.—Vision very much better. The eyes have now recovered from the operation. Tension normal.

27th.—Patient discharged.

Remarks.—This case presents several points of interest to which attention may now be drawn. First, it was elicited on inquiry from the patient that four years previously she had been informed by an ophthalmic surgeon whom she consulted that she was suffering from chronic glaucoma in each eye. At that time she sought advice in consequence of failing vision, and the surgeon then warned her that subsequently it might be necessary to operate upon her eyes. The vision had still continued to fail slightly from that period up to the time of her admission, but never at any time had there been any pain or redness in the eyes. Then came the operation for ovariectomy, which, nevertheless, was quite uncomplicated, and from which she made an excellent recovery. On the fourth day following the operation, however, symptoms of subacute glaucoma developed in the left eye. Under the belief that the sudden increased tension was merely temporary, and would subside under treatment, hot fomentations and eserine drops were employed. For a time improvement resulted from this, but subsequently a large upward iridectomy was done. The precautionary measure was at the same time adopted of keeping the right pupil under the influence of eserine, but, as the sequel showed, this proved to be quite unavailing, inasmuch as five days after the operation upon the left eye the right one became the seat of a subacute glaucomatous attack, for which, in the course of forty-eight hours, a large upward iridectomy was required. On testing the vision previously to the discharge of the patient, that in the right eye was found to be 6-18 nearly; that in the left 6-24.

A point of interest was the failure of the eserine drops to arrest the development of the attack in the right eye. Despite the fact that for some days the right pupil was kept strongly contracted by means of the myotic, the glaucomatous attack nevertheless developed.

Again, what was the connection between the ovariectomy and the sudden onset of the subacute glaucoma-

tous symptoms? Experience has amply taught that a close connection exists between inflammatory glaucoma and physical or mental shock. Either one or the other, singly or combined, is, or has been, present in the majority of cases of patients who are the subjects of the disease. On the other hand, what is the connection between glaucoma and shock? The answer to this involves the whole question, which is still to be determined, of what glaucoma is. In the simple or chronic form of the disease—that in which iridectomy, so invaluable in the treatment of acute cases, is apt to prove commonly more harmful than useful—the symptoms are so modified as scarcely to fulfil the description of a glaucomatous attack. Indeed, in many instances, save for two exceptions, the cardinal signs of glaucoma are absent; these exceptions being excavation of the disc and failure of vision. Thus there is much which can be said for Graefe's contention many years ago, that these cases of simple glaucoma should not be described as glaucoma at all, but as those of amblyopia associated with excavation of the disc. And yet we are compelled to remember that, unless these cases are regarded as glaucomatous, in advertent treatment may expose the patient to the risk of the supervention of total blindness; for should a mydriatic be casually instilled into an eye in which simple glaucoma is present, in a few hours afterwards an acute attack of the disease would probably be the result. Nothing, then, can show more clearly than such a catastrophe as this how little we know of the true etiology of that disease which is described as glaucoma.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON.

MEETING HELD FRIDAY, MAY 26TH, 1905.

The President, Dr. FREDERICK TAYLOR, in the Chair.

Drs. F. TAYLOR and J. FAWCETT described a case of MILKY ASCITES IN WHICH THE OPALESCENCE WAS NOT DUE TO FAT.

The patient, æt. 31, was admitted into Guy's Hospital on October 6th, 1904, and died a month later. His illness commenced in May, 1904, with œdema of the legs and face, followed by ascites, for the relief of which paracentesis was performed, in all nine times. The fluid removed was always milky and this appearance was at first thought due to fat but under the microscope no fat globules, but only granules were visible. On admission the urine was found to contain about 14 parts per 1,000 of albumen, and casts were present. No other signs of disease with the exception of the ascites and nephritis were found. At the autopsy there was milky fluid in both pleuræ and a large amount in the peritoneal cavity. The kidneys exhibited the typical aspect of a tubal nephritis. The other viscera appeared healthy. The pancreas weighed only 60 grammes, but microscopically its structure was normal. Clinical examination of the fluid by Mr. J. H. Ryffel gave the following result:—

Fat, 0.45 per cent.; proteid, 3.96 per cent.; iodine, 0.966 per cent. as potassium iodide; chlorine, 2.64 per cent., probably as chloride.

Mr. R. W. ALLEN reported that no fat globules could be detected under the microscope nor extracted with ether; on precipitation with ammon. sulphate the fluid became quite clear. *Remarks:*—The analysis and examination show that the milky appearance was not due to fat, but probably to proteid in some form. The amount of fat present was only 0.45 per cent. Lactescent serous effusions in which the opacity is thought to be due to a proteid have been ascribed to (1) lecithin, (2) mucoid substances, (3) to a proteid resembling casein. Joachim and Von Beinert in some recent researches point out that albuminous bodies of the globulin group may have their solubility lessened by chemical combination with lecithin or by molecular arrangement, their conclusion being that the milkiness is probably due to a combination t

lecithin and a proteid. Attention was also drawn to the association of lactescent serum and the presence of nephritis, as previously noted by Bright, Castaigne and others.

Mr. JAMES BERRY read a paper on a case of Syphilitic Destruction of the Nose treated by a plastic operation.

The patient, a gentleman, æt. 33, had acquired syphilis nine months before coming under observation. For three months he had had no treatment; he had then been treated with mercury, but the whole of the left ala had by then sloughed away.

Under iodide of potassium the ulceration of the nose had quickly healed, but a large hole was left, exposing freely the interior of the nostril. The patient was at first fitted up with an artificial aluminum ala which he wore for three months, but as he was about to go to the East for some years, he was not content with this. The following plastic operation was therefore performed:—An incision two inches long was carried along the side of the nose from the tip nearly to the inner canthus of the eye. A second incision of nearly equal length went from the upper end of the first downwards and outwards along the outer border of the naso-labial bridge, then crossing this and ending on the cheek an inch external to where the ala should have been. The thick flap of skin and muscle thus formed was twisted round, doubled on itself, and fixed to the nose in such a manner that what had been the highest point of the flap was sutured to the lowest point of the nasal incision; the doubled up flap itself thus formed a prominent new ala which completely covered up the gap in the side of the nose. The triangular raw surface thus left between the eyelid and the nose was then closed up by transverse suturing aided by under-cutting and by a deep tension stitch of stout fishing-gut passed from the centre of the cheek to the middle of the nose. This stitch was left in place for seven days. At the end of this time firm primary union had taken place. The patient was left with a prominent and fairly shapely ala with which he was pleased and a nostril through which he could breathe freely. The scar was thus a linear one placed in the furrow between the nose and cheek where it was scarcely noticeable. Neither lower eyelid nor upper lip were in any way drawn out of place by the operation. The paper was illustrated by several photographs of the nose before and after operation.

Mr. CAMPBELL WILLIAMS pointed out that plastic operations for syphilitic ulcers were usually followed by poor results. He attributed the brilliant success of the present case to the fact that the ulcer followed soon upon the primary inoculation. The longer this interval was the less amenable was the ulcer to treatment. He would advise three years mercury treatment of this patient.

Mr. BARNARD asked whether any success had followed on similar plastic operations for syphilitic necrosis of the hard palate.

Mr. WALTER G. SPENCER referred to several cases of palatal necrosis that he had operated on with success.

Mr. BERRY replied.

Drs. SIDNEY PHILLIPS and B. H. SPILSBURY read a paper on a case of

PRIMARY ADRENAL CARCINOMA OF THE LIVER.

The patient, a married woman, æt. 40, suffered from loss of appetite, nausea, and occasional vomiting for about 10 months before she noticed that the abdomen was enlarging. She then took to her bed. A month later, on December 15th, 1904, she came into St. Mary's Hospital, with enormous enlargement of the abdomen, copious ascites, and great wasting and debility; after removal by a trochar of 386 ounces of clear yellow liquid from the abdomen, the liver could be felt enormously enlarged and with nodules of all sizes projecting from it. The left lobe seemed to be a mass of nodular outgrowths, the right lobe was less universally nodular; there was no pain, no jaundice, and no pyrexia. Besides the nodules to be felt in the liver, many small nodules could be felt within the abdominal cavity—some freely movable, and others

situate just beneath the abdominal wall, and feeling very like lymphatic glands; they were evidently nodules of growth in the peritoneum and omentum. The patient died of exhaustion on December 27th. The necropsy showed the left lobe of the liver to be almost replaced by firm, white-coloured growth, which formed nodules of all dimensions projecting from the surface, and some of them umbilicated. The right lobe was full of similar nodules, but was less extensively invaded by the growth. A hard mass of growth, the size of a large walnut, was attached to the peritoneum in the region of the junction of ascending and transverse colon, and the peritoneum was infiltrated with small soft centres of growth; some of these small masses were quite cystic with contained yellow liquid. There was some of the same growth near the pancreas, but not involving this gland. The suprarenal glands themselves were quite healthy.

Microscopic specimens prepared by Mr. Spilsbury and exhibited at the meeting, showed that the growth in the liver and in the nodules in the peritoneum presented the characteristics of a carcinoma originating in the suprarenal cortex; the tumour cells were for the most part arranged in single rows, or in double rows around a central lumen, an arrangement suggestive of a tubular carcinoma; there was only a small amount of fibrous tissue between the rows of cells, and in places the cells rested directly upon the endothelium of the capillary blood-vessels; the blood-vessels within the nodule were only a few capillaries; the tumour cells ranged in shape from cubical to a deep columnar; they had a delicate cell outline and their protoplasmic contents stained faintly with acid dyes; the nuclei were large and vesicular. The surrounding liver was compressed, the cells small and atrophic. In the left lobe of the liver scarcely any remnants of liver substance were present; the large white masses consisting of collections of tumour cells separated by broad bands of dense fibrous tissue, and individual cells showed degenerative changes. The growths in the peritoneum and the nodule in the neighbourhood of the pancreas showed the same features as the mass in the left lobe of the liver.

REMARKS.—The occasional existence of accessory suprarenal bodies in the viscera, such as kidney peritoneum, had been described by various observers. Schmorl in 1891 had been the first to record the discovery of such aberrant "rests" in the liver; in four cases in which the suprarenal glands were themselves quite normal there were nodules of suprarenal tissue in the liver substance. Obendorfer had described two other cases. Peperé, who had investigated the subject with great minuteness, concludes that germs of adrenal tissue may, during embryonic life, become included in the substance of the liver tissue. They may consist of cortical or medullary substance, or of both; the cells of these adrenal "rests" may give origin to neoplasms of epithelial type, reproducing the structure of adrenal tissue. Peperé describes the first recorded example of malignant disease from such included suprarenal tissue on the liver; and Dr. Phillips's case exactly resembled it in clinical and pathological characters. Both cases were in women aged forty years—in both the liver was greatly enlarged and nodulated, there was much ascites and no jaundice. The course in both was rapid to a fatal issue. Clinically, Dr. Phillips said, it was impossible to distinguish this form of carcinoma of liver from the forms more ordinarily met with, though in the latter it was rare to get ascites without jaundice.

Dr. PARKES WEBER asked whether there had been any clinical evidence of excess of suprarenal secretion, in the form of high tension pulse or skin changes.

Dr. SIDNEY PHILLIPS replied in the negative.

Sir DYCE DUCKWORTH read a paper on a case of DIABETES MELLITUS IN WHICH XANTHOMA APPEARED—LIPÆMIA—FATTY NECROSIS OF THE PANCREAS.

The patient, æt. 23, was shown to the Society in December last. The disease ran an acute course, and terminated fatally within six months of the onset of diabetic symptoms. The xanthoma papules ap-

partment for treatment. If there had been sufficient time he should like to have gone thoroughly into the matter by collecting statistics from all available sources, for no opinion could be based upon the imperfect scraps of figures which he had ventured to quote. They served, however, to show the magnitude of the numbers involved, and how very easy it might be to be led into mistaken ideas upon such a question as the prevalence of adenoid hypertrophy, which it was possible upon careful investigation might prove to be no greater than that of a number of other common ailments.

Mr. GRIFFITH WILKIN said a few words in reply. The resolution was then put to the meeting and lost.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING HELD AT THE HOSPITAL FOR WOMEN, LEEDS, ON MAY 26TH, 1905.

Dr. LLOYD ROBERTS, President, in the Chair.

MYO-FIBROMA OF THE VAGINA.

Dr. E. O. CROFT (Leeds) showed an example of this rare condition, which formed a solid tumour whose free rounded portion projected for an inch into the vaginal canal on its left side, reaching within half an inch of the urethra. The upper portion of the vagina was normal, as were the uterus and appendages. There was an excoriation on the most prominent part of the growth which caused slight bleeding occasionally. The tumour was easily shelled out and removed with a redundant portion of vaginal mucosa. In shape it resembled a cottage loaf, and it was about two inches in diameter. Microscopic examination proved it to be a myoma. Of fifty-four vaginal growths only three were of this nature. They are always single, generally occupy the middle line, and are usually sessile.

CHORIO-EPITHELIOMA.

Dr. C. OLDFIELD (Leeds) described a case of chorio-epithelioma of the uterus associated with bilateral ovarian cysts of lutein origin. The patient had a vesicular molar pregnancy which was followed by chorio-epithelioma. There were multiple ovarian cysts on each side, one of them larger than a foetal head. These were removed as well as the uterus. Microscopic sections demonstrated the presence of a large amount of lutein tissue in the walls of the cysts. The relation observed between excess of lutein tissue and the occurrence of vesicular degeneration of the chorion was described, and it was explained that while the normal corpus luteum presides over the embedding of the ovum, the presence of excess of lutein tissue causes overgrowth of the chorionic epithelium—the essential feature in vesicular degeneration of the chorion. From this it was an easy step to the production of chorio-epithelioma.

PSEUDO-HERMAPHRODITISM.

Dr. A. STOOKES (Liverpool) showed photographs and casts from an individual, æt. 18, with large breasts and a distinctly feminine appearance, who had a large clitoris with a distinct glans, ridges representing labia majora and slighter ridges representing labia minora, and leading to the meatus urinarius. There was no trace of hymen or vagina. On the right side there was a large inguinal canal with an ovarian or testicular structure projecting into the labium majus, a similar structure accompanying the upper portion of the left canal. The shoulders were wider than the hips. There was sexual inclination towards the female, and though brought up as a girl, the patient wished to assume the male dress and become a sailor.

Dr. S. BUCKLEY (Manchester) described an individual, æt. 20, brought up as a female, whose face had to be shaved, whose breasts were quite undeveloped, and who had hair on the chest. There was a penis, 2 ins. in length, with glans and wrinkled prepuce. Erections occurred, when the dimensions of the organ were doubled. The urethra opened at the base of the penis between small labia minora and majora. There was a minute orifice through which a sound could be passed 4½ ins. There was no suggestion of uterus or appendages except a structure in the position of the left ovary resembling a coffee bean in size. There had

never been any menstrual discharge or molimen, and there was sexual inclination toward the female.

Dr. W. GORDON FITZGERALD read a paper on "Vaginal Ruptures in Connection with Parturition, based upon four recent cases and about fifty collected cases." The mortality was very high, and treatment by abdominal section was thought to present the best chance of success.

France:

[FROM OUR OWN CORRESPONDENT.]

PARIS, June 4th, 1905.

ALOPECIA AND HAIR DYES.

ALOPECIA in women is frequently caused by pityriasis, but still more frequently no local cause can be assigned. In any case the treatment is about the same, although the preparations must be varied in order to obtain rapid results; it is also indispensable to apply the solutions with a hard brush.

The following formulæ will be found useful:—

Hoffman's anodyne, 6 ozs.;
Spirits of camphor, 1 oz.;
Spirits of lavender, 1 oz.;
Nitrate of potash, 10 grs.;
Formol (of commerce), 15 mim.;
Water, 2 ozs.

Hydrochlorole of pilocarpine, 10 grs.
Rose-water, 2 ozs.;
Proof spirit, 6 ozs.;
Ether, 1 oz.;
Spirits of lavender, 1 oz.

Acetone, 3 ozs.;
Proof spirit, 3 ozs.;
Liq. ammonia, 1 drachm;
Water, 2 ozs.;
Caffeine, 10 grs.;
Ess. of violette, 1 oz.;
Tincture of capsicum, 4 drachms.

This treatment, well applied, rapidly arrests the fall of the hair. At the end of about three months new hair sprouts, especially if the parts have been vigorously brushed. At the end of a year the new hair attains about five inches in length.

The above treatment will not give the same result in men, for with them it is generally a case of progressive baldness.

Many ladies accept with difficulty the encroachments of advancing age especially when indicated by silvered hair, while others, discontented with the colour of the hair given to them by Nature, considering it to be out of harmony with their complexion, desire to find a substitute to their choice.

Amongst the best colouring solutions are the following:—For black hair, nitrate of silver and pyrogallic acid are the substances generally employed. The hair should be first washed with soap to remove grease, and dried, when the following application should be made:—Nitrate of silver, 1 drachm; acetate of lead, 15 grs.; rose-water, 3 ozs.; eau de Cologne, 15 m. After the solution is rubbed in, the head should be washed in salt water to prevent colouring of the skin. Generally two tinctures are employed, one of nitrate of silver, the other of pyrogallic acid, as follows:—Nitrate of silver, 1 drachm; water, 2 ozs. Pyrogallic acid, 1 drachm; spirits of wine, 3 drachms; water, 2 ozs.

If a brown dye is desired, the amount of pyrogallic acid should be diminished. The abuse of these dyes provokes irritation of the scalp (eczema).

For blonde hair, oxygen water is about the best agent for producing fair hair, but it makes it brittle. It should be employed several successive days, and the bottle kept well corked. A decoction of rhubarb (6 oz. to one pint of white wine, and reduced by boiling to half the quantity) can be used for the same purpose. Henna gives a red or yellow colour. Powdered henna mixed with water so as to form a paste is rubbed into the hair. At the end of an hour the hair becomes

prove fatal from the oedematous condition due to the laceration and stretching in Loreta's operation.

Dr. FISHER asked if peristalsis was necessarily diagnostic of stenosis. In one case under his care peristalsis was well marked, but the child escaped operation.

Dr. CAUTLEY remarked that the case illustrated the importance of early operation, that the pylorus could be easily felt if the child were allowed to waste sufficiently, that the wasting was a serious bar to successful treatment, and that the prognosis was that of the anarasmic state of the child at the time of operation, and not that of the particular mode of operation, and that it also depended largely on the management of the diet after operation. He held that many cases could be cured without operation if a diagnosis of the condition was made on slight evidence. Though he knew mild degrees of the condition existed and lived for years, he believed that almost every one of the so-called cases of recovery without operation were due to erroneous diagnosis. He fully believed in the existence of simple pyloric spasm, apart from this condition of hypertrophy. He did not regard peristalsis as an essential feature in the diagnosis, nor the palpability of the pyloric tumour. Both these signs developed as the case progressed, but the best results were in those cases diagnosed at an early date, and he maintained it ought always to be possible to recognise the condition within six weeks of birth. In several of his cases the operation had been done in the fourth or fifth week of life. Pyloroplasty was, in his opinion, the best operation, as the one most likely to produce a permanent cure and a satisfactory local condition.

Dr. L. W. MARSHALL (Nottingham) showed a specimen of Multiple Papillomata of the Larynx, from a boy, *æt.* 4.

Dr. PORTER PARKINSON showed a girl, *æt.* 7, with Multiple Gummata in thighs, legs and forearms. He also showed a baby, *æt.* 4 months with Bilateral Palsy of the Arms, due to difficulty at birth and probably injury to the brachial plexus.

Mr. HUNTER TOD showed a case of Primary Tuberculous Disease of the Middle Ear and Mastoid, with secondary involvement of the cervical glands.

BRITISH LARYNGOLOGICAL, RHINOLOGICAL, AND OTOLOGICAL ASSOCIATION.

GENERAL MEETING HELD ON FRIDAY, MAY 12TH, 1905, AT THE MEDICAL SOCIETY'S ROOMS.

The President, Mr. CHICHELE NOURSE, in the Chair.

CASES were shown by Mr. Mayo Collier, Dr. W. H. Kelson, Dr. R. H. Abercrombie, Dr. Wyatt Wingrave, and the President.

Mr. GRIFFITH C. WILKIN read a paper on THE PREVALENCE OF ADENOIDS, which will be found under the heading of "Original Communications," on page 539. He moved the following resolution:—"That in the opinion of this meeting it is desirable to appoint a Committee to investigate thoroughly the question of the prevalence of adenoids in the child life of the country, and its importance on the national stamina."

This was formally seconded by Dr. VINRACE, who said that he held that preventive medicine was more properly the domain of the medical officer of health, and that in this instance hygiene—*e.g.*, sanitation, ventilation, the proper feeding of infants and children—played a most important part in the development of adenoid growths. He was much indebted to Mr. Wilkin for bringing forward the question, and he felt that the Association had sufficiently considered the projected Committee to arrive at the conclusion that it was a movement called for at their hands.

Dr. WYATT WINGRAVE questioned the expediency of the resolution. The subject of adenoids was not unfamiliar to the general practitioner, and was even now recognised by the general public, therefore no anxiety need be felt for the national stamina on the score of adenoids. He felt that State interference in the matter

might be interpreted as an interference with the liberty of the subject, and so arrest the rapidly growing personal interest by parents. Further, that any addition to the already weighty burdens and responsibilities of the State and local governments would not meet with cordial acceptance by ratepayers. He found that a large number of children who were brought to the hospital on the parents' initiative as adenoid sufferers had no adenoids at all. This he interpreted as strong evidence of the rapid spread of parental interest in the subject, and a strong argument against unnecessary professional interference.

Mr. ATWOOD-THORNE wished to know whether Mr. Griffith Wilkin had approached the Childhood Society or some other society interesting itself specially in national stamina. He quite agreed that in London parents were too prone to bring their children for operation, but most of those present could only speak for London, while it was quite probable that in the country the disease was not so fully recognised. As for compulsion, children who gained scholarships in the London County Council's schools were examined physically already, and if adenoids were detected removal was required before the benefits of the scholarship could be obtained.

Mr. WIGG said, although he was unable to vote for the appointment of a Committee at the present time, he felt much sympathy with the proposal. He thought that before taking such a step it would be desirable to sound the sister societies and ascertain if they would lend their support. He held that there was much in the incidence of adenoids which it would be well for a Committee to inquire into, and it concerned the honour of the profession to do its utmost to assist in the prevention of this ailment as of others.

Mr. CHICHELE NOURSE (the President) remarked that it should be first ascertained to what extent adenoid hypertrophy is prevalent in town and in country; and while he had no wish to underrate its frequency, it was necessary to avoid exaggeration. Opinions upon the relative frequency of adenoids must be based upon the actual examination of a series of cases, and not merely upon observations upon mouth-breathing, snoring, and other external signs; for, although a mass of adenoids might produce well-marked nasal obstruction, the habit of mouth-breathing was not in itself a proof of the co-existence of adenoids. Again, the conditions in the country and in town were so widely different that he thought the two cases should be separately considered. With regard to the country, his recollections of a rural district in Devon—where the air was pure and almost germ free, where the people were leading outdoor lives, and where suppurative ear-disease and middle-ear deafness were very rare—made him doubt strongly whether adenoids are really very prevalent in such localities. He would have been glad to correct his impressions by means of trustworthy statistics which he hoped Mr. Wilkin would have been able to furnish. In the absence of these, it was only possible to form a most imperfect judgment. In respect of towns, it must be still more difficult to reach a satisfactory basis for any conclusion. In London, for instance, in June, 1904, according to the London County Council, there were 968,007 children of school age. If 1 per cent. of these required operation for adenoids, there would be enough to do. The total number of operations for adenoids performed in a year at the Central London Throat, Nose, and Ear Hospital, (1904), Golden Square (1904), and the London Throat Hospital (1903, as the report for 1904 was not available), amounted to 4,971 only. Besides these, all the cases operated on at other hospitals and in private must be reckoned. At the North-Eastern Hospital for Children, in 1903, 19,318 patients applied for treatment, and operations for enlarged tonsils and adenoids were performed in 359 cases. At the same hospital in the following year the total number of new patients was 19,267, and the operations on tonsils and adenoids 513. It appeared to him that if any child attending that hospital showed marked signs of nasal obstruction, it would almost certainly be referred to the throat de-

apices of the lungs chronic tuberculosis was unquestionably present.

The histological examination proved the large tumour to be partly composed of spindle-shaped sarcoma cells and partly of spindle-shaped healthy cells, while another portion resembled glandular cell-tissue with cylindrical epithelium. The wall of the dermoid cyst contained epidermis, hair, and cylindrical epithelium, embedded in nuclear tissue. He therefore concluded that there was no direct connection with the dermoid cyst and large tumour, but the latter might be the result of the former from metastasis.

Franqué thought that the histological examination of the dermoid cyst proved it to be a glandular tissue resembling the normal covering of an ovale, which might have accidentally become detached and fixed in the abdomen. The theory of metastasis was a remote contingency; although many gynæcologists and surgeons had found lymphatic gland tissue in cancerous uteri which had been attributed to metastasis. This, he thought, should be received with caution, as no such glandular tissue can be found in the dead body. Mayer had reported several cases in which he had shown that the degeneration of cancerous tissue may be altered by increased stimuli, and made to resemble the lymph endothelium of a lymphatic gland. Was such a transformation not likely in this complicated case?

At this point Franqué, whose case it was, gave the clinical history. The patient, two months previously, complained of swelling at the lower part of the abdomen, associated with depression and rapid emaciation. At this time no tumour could be observed in the right side, although ascites was present. After consultation, a doubt was established whether the case was a formation of a malignant tumour or abdominal tuberculosis. To differentiate the diagnosis a tubercular injection was administered which reacted, giving a temperature of $38\frac{1}{2}^{\circ}\text{C}.$ — $101\frac{1}{2}^{\circ}\text{F}.$, and supporting the presumption of tuberculosis. All operations were then abandoned, and medical treatment resorted to, such as hot air, with the object of producing active hyperæmia of the peritoneum.

To avoid any mistakes, Bier's apparatus was applied around the lower portion of the body at four different periods, with a temperature of $120^{\circ}\text{C}.$ — $248^{\circ}\text{F}.$ The patient expressed great relief after this exposure, the ascites diminished, and the general condition was greatly relieved. Two days after the last application of the hot air, however, she complained of great pain in the abdomen, vomiting and collapse ensued, and two days later she died.

The *post-mortem* revealed the sequence to the members. The hyperæmia produced by the hot-air treatment was evidently the unfortunate cause of the rupture and hæmorrhage of the tumour into the abdomen. This object-lesson should be a warning to all adopting the hot-air treatment that it is not free from very serious consequences.

SHRINKING OF THE KIDNEYS.

Rohn reported a case of shrinking of the kidneys to the members in a female child, 3 months old, where thrombosis of the vena renalis had been the cause. The right kidney measured 22 mm. in length, 13 mm. in breadth, and 3 mm. thick, while the left was 35, 26, and 20 respectively. It had the appearance of a thin disc, normal colour, with nephritic parenchyma. Both ureters were patent, the right being narrower than the left. During life no nephritic phenomena were observed, although this must have resulted from a severe chronic gastro-enteritis followed by a marasmic thrombus.

Hungary.

[FROM OUR OWN CORRESPONDENT.]

BUDAPEST, June 2, 1905.

SUGGESTIONS ON THE PREVENTION OF CHLOROFORM FATALITIES.

DR. HASENFELD recently contributed an interesting paper on "Circulatory Disturbances Resulting from Laparotomy performed under Chloroform Narcosis," in which he offers some useful suggestions. He says the induction of chloroform narcosis and abdominal

section are operations each of which is capable alone of injuriously influencing the circulation. It is, therefore, easy to understand that this noxious effect on the organs of circulation (heart and blood vessels) may sometimes prove dangerous to the patient. This fact explains how it is that deaths during the performance of the operation, the so-called "death under chloroform," as well as the cases in which the patient dies soon after the operation, with symptoms of gradually increasing heart failure, are still frequent. Up to the present no suitable means of averting or combating these disturbances following on laparotomy performed under chloroform has come into general use.

This practically very important object has been sought to be attained by Dr. Hasenfeld according to the following principles:—(1) We must support the heart in its action in order to enable it to resist the fall in the blood-pressure by greater activity. (2) We must remedy the diminished tone of the blood vessels as far as possible. (3) We must apply such methods for the maintenance of the quantity of blood stagnating in the dilated vessels (and therefore lost to the circulation), as if we had to deal with severe hæmorrhage.

In this direction Dr. Hasenfeld carried out a series of experiments on animals, and he attained certain results, which he sums up as follows: (a) Chloroform narcosis and abdominal section each tend to induce a fall of the blood-pressure, and *a fortiori* when they operate together. (b) This fall in the blood-pressure is due to paralysis of the vessels. (c) The sinking of the blood-pressure is gradual, and ultimately leads to arrest of the circulation and respiration respectively. (d) We can put a stop to the dangerous fall of the blood-pressure, which sets in at a later period after laparotomy; it is even possible to determine a permanent and considerable raising of the blood-pressure. (e) To attain this object the most appropriate method is to endeavour to raise the power of the heart (perhaps also, the tone of the vessels), and also to increase the quantity of fluids circulating in the vessels. This method is successful even when the narcotised laparotomy patients suffer a considerable loss of blood. In these investigations the best results were obtained by the Bohring digitalinum and the intravenous injection of normal saline solution.

At the last meeting of the Royal Society of Physicians of Budapest, Herr Lukács showed a case of

ENCEPHALOPATHIA INFANTILIS.

The patient suffered during dentition from a febrile disease, after which paralysis developed on the left side, and still exists. The patient became subject to a mild form of epilepsy, and was imbecile. This disease has no characteristic name, but is described from its most prominent symptoms. The reason for this we must seek in the fact that the three symptoms mentioned participate in the disease in a very variable degree. Dr. Lukács recommends the term—largely used by the French physicians—"encephalopathia infantilis."

TRAUMATIC MUSCLE-PARALYSIS.

Dr. Por showed a patient who sustained a blow on the left eyebrow from the shaft of a carriage. He could not open his eye on account of the great swelling for a week. When he was able to do so he complained of double vision in every direction. The restriction of the eye movements and the diplopia supported the assumption that the inferior rectus and external rectus muscles were paralysed. How this condition was caused he was unable to decide. He related this case only for the reason that traumatic muscle-paralysis is very rare.

The plague mortality throughout India has again shown a rise; for the week ending April 29th there were returned 56,732 deaths, as against 54,602 for the previous seven days.

THE North-Eastern Hospital for Children, Hackney Road, has received an anonymous donation of £100 towards the up-keep of the one hundred and sixteen beds which the institution has now in constant use.

Continental Health Resorts.

[FROM OUR OWN SPECIAL CORRESPONDENT.]

SAINT GERVAIS-LES-BAINS (HAUTE-SAVOIE).

THIS summer resort, so picturesquely located in one of the Arve valleys and near the great mountains of the Mont Blanc group, offers two distinct yet concordant therapeutic elements, viz., a mineral water "cure" and a climatic "cure."

It has three mineral springs, one, the "Torrent," saline-sulphurous; the two chief springs, "Gontard" and "May," have temperatures of 40° and 38° C., and a mineralisation of almost 50 per cent., showing the following analysis:—

Chloride of sodium,	1.65
Sulphate of soda,	} 3
Sulphate of lime,	
Sulphate of magnesia,	
Bicarbonate of lime,	'60
Bromure of sodium,	'031
Sulphate of lithine,	'102.

The latter constituent places these Saint Gervais Springs at the head of the lithinated waters of the Continent; only one other Spring being comparable with them in this respect.

In an able address delivered on the spot to a Medical assembly, Professor Landouzy called especial attention to the numerous gas-bubbles escaping from the surfaces of the springs as the water arises, and containing 10 per cent. of carbonic acid and 90 per cent. azote. He attributed their physiological action to the presence of "Na C." and of "sulfates alcalino-terreux. C'est un lympe naturelle, un veritable serum, le milieu interieur de Claude Bernard."

The Saint-Gervais waters are administered internally, as well as applied externally. Internally, they excite the gastric, intestinal, and hepatic glands; producing a gently laxative and especially desirable diuretic effect; also a sedative action on the nervous system.

Externally, because of their natural temperature and composition, their effect is sedative and decongestive. The very desirable situation and atmosphere of Saint Gervais add considerably to the sedative action of the treatment by the mineral waters, but without making this action too strongly marked.

The action of Saint Gervais waters upon the stomach and annexed glands is very efficacious against gastric and intestinal dyspepsia in anarthric cases; increasing appetite by curing constipation, producing a better assimilation of food, and restoring to the skin its normal organic functions. It is a peculiar and advantageous fact that the action of these waters is not, as too frequently with other and stronger mineral waters, temporary, spasmodic, and abnormal. On the contrary, the Saint Gervais waters gently and steadily reproduce the normal digestion thoroughly, and with beneficial effects which continue long after a sojourn here.

The principal reputation of Saint Gervais has hitherto been for the successful treatment of cutaneous affections, eczemas especially, and particularly neuro-arthritic eczema. Nowhere else have the resident physicians had more experience in the successful application of mineral waters to such cases; and nowhere else exist more facilities for such applications successfully. Recently, another special feature of Saint Gervais "cure" has attracted much medical attention—the marked influence of these waters to neuro-arthritic children, and to young people. Of this, and of the climatic advantages of the Station we will say more hereafter.

The Paris, Lyons, and Mediterranean Railway directly connects Saint Gervais with Geneva, Evian, Aix-les-Bains, and Annecy; its terminal station being at Le Fayet, close to the Saint Gervais Thermal Establishment; in the large park of which establishment are the Grand Hotel de la Savoie (an elegant house with all modern luxuries), and the very comfortable family Hotel des Bains. Both houses are under the same

excellent management, and in the same Park are the Casino and other amusements usual at Continental Spas. From the Le Fayet railway station, an electric line runs up to Chamonix (for Mont Blanc) through the grandly picturesque valley of the Arve river

Operating Theatres.

FRENCH HOSPITAL AND DISPENSARY.

OPERATION IN A CASE OF JACKSONIAN EPILEPSY.—Mr. Edmund Owen operated on a man, æt. 34, who had been admitted two months previously, and whose history was as follows:—In July, 1891, whilst doing his military service in a cavalry regiment in Algeria, he fell from his horse on the roadway, striking the left side of his head on a large stone. Being alone at the time, he lay unconscious on the road till brought in by a picket. On admission to the military hospital he was found to be suffering from a depressed fracture of the upper and anterior quarter of the left parietal bone. He regained consciousness next morning, but was discovered to be suffering from enteric fever, and on this account operation was delayed till December, 1891, when M. Chevasse, the regimental surgeon, trephined for relief of the irritable effects of depressed fracture. During the next five years he remained in good health, except for slight neurasthenia and disinclination for monotonous employment (shoemaking), but in 1896 he began to suffer from Jacksonian epilepsy. The attack was ushered in by twitching of the right hand and right face, the clonic convulsions spreading to the right lower extremity, followed immediately by loss of consciousness and snoring respiration. The patient, a markedly intelligent man, avoided injury by lying down whenever threatened by an attack. He frequently bit his tongue, but did not pass urine involuntarily during the attack. Recovery of consciousness was followed by a tonic contraction of the right foot and hallux, lasting for several days; the attitude of the foot being that of equino varus (equinus less marked than varus) and powerful dorsiflexion (=extension anatomically) with adduction of the right hallux. For these symptoms he was operated on at Lyons in 1896 by Professor Ollier, the operation consisting of the removal of a further portion of the parietal bone. This operation gave an immunity from symptoms for about eighteen months, when the condition of Jacksonian epilepsy recurred. For this recurring Jacksonian epilepsy further operations were undertaken, viz.:—Third operation, Paris, by Professor Duplay, at Hotel Dieu, 1898; fourth operation, Paris, by Professor Terrier, at La Pitié, 1902; fifth operation, Paris, by Professor Terrier, at La Pitié, 1903. In each case the operation was followed by immunity from attack, and when the attacks recurred the patient returned for operation without delay. Being in London at the beginning of 1905, his troubles recommenced, and he was admitted to the French Hospital the morning after an attack under the care of Dr. Leonard Williams.

CONDITION ON ADMISSION.—The patient walked to hospital evidently lame in the right leg. His intelligence was perfect, and far above the average of hospital patients. His speech was unimpaired, and his ideas were clear. He was well nourished and had no symptoms pointing to any affection except of the nervous system. Heart, lungs and abdominal organs were healthy.

CONDITION OF THE NERVOUS SYSTEM.—In the upper and anterior quarter of the left parietal region, there was a large depression due to the removal of bone

over an area of 4 inches by 3½ inches. The scalp was adherent to the subjacent structures, and showed respiratory and cardiac pulsations. Inferiorly to the bony edge of this depression there were three concentric incision scars of previous operations.

HEAD.—Special senses unimpaired and general sensation perfect. Eyes: Pupils equal reacting to light and accommodation. Ophthalmoscopic examination: Discs healthy, no nystagmus. Left side of face appeared to be paresed when compared with the right side, but this appearance was due to over-action of right side of face. Emotional movements of each side as well as the voluntary movements were unimpaired.

UPPER EXTREMITY.—Right slightly weaker than left; very slight extension tremor. No disturbance of sensation; reflex or vaso-motor functions.

LOWER EXTREMITY.—Attitude as above described. The tonic condition confined to the extensor group of muscles of leg. Large scar of burn on outer side of mid-thigh from hot-water bottle after operation. *Reflex functions:* (a) Deep reflexes; knee jerk much increased; ankle clonus present. (b) Superficial; Babinski sign very marked; tensor vaginae femoris, reaction present. *Vaso-motor* and trophic functions unimpaired. The left side of the body was unaffected. Mr. Edmund Owen saw the patient in consultation with Dr. Leonard Williams, and noting the deep cup-shaped depression where the scalp was drawn down to the brain, expressed his fear lest operative treatment should fail to bring permanent relief. The great depth of the depression showed that there had evidently been considerable loss of brain-tissue, and he thought that the peripheral troubles were probably as much due to contraction of scar-tissue in the cerebral cortex as to adhesions which might have formed between the brain and the dura mater. But though he was not able to advise, and still less to urge, the performance of an operation, he thought that he would be justified in giving the man the benefit of an exploration, as desired by Dr. Williams and also by the patient. Mr. Owen remarked that it not infrequently happened that when a surgeon entered upon an operation in what seemed to be an almost forlorn case, the conditions actually met with proved less insurmountable than had been anticipated, the procedure being finished with fair prospects of success. And so, apparently, it turned out in this case. A flap of scalp was marked out down to the bone skirting the edge of the gap in the skull, and with it was raised the dura mater, which in the upper part was closely adherent to the soft scar-tissue in the cortex. Bleeding having been checked, Mr. Owen temporarily fixed the flap in position by five sutures of silkworm gut and said he intended next day to re-open the wound, and to introduce a thin sheet of gold between the brain and the dura in order to prevent the further development of adhesions. Accordingly on the following day, Mr. Owen re-opened the wound, letting out a good deal of venous blood which had collected, and, having laid in the gold plate, permanently closed the wound. After the lapse of four days, it is satisfactory to report that the man has remained perfectly comfortable since this operation, and that there has been no staining of the dressings or any other indication for disturbing the wound.

As the result of a recent luncheon at the Mansion House, over £4,000 will be handed to the North-Eastern Hospital for Children, towards the reduction of the debt.

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The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, JUNE 7, 1905.

THE MEDICAL DEFENCE UNION.

It is gratifying to find that our pioneer and most excellent institution, the Medical Defence Union, continues its excellent work in the interests of the medical profession. As the parent Defence Society, its progressive developments of policy and advance in material prosperity will naturally be followed with special interest by medical men. First and foremost, its financial condition appears to be in a satisfactory state. Above all things, it is satisfactory to note that a good beginning has been made towards the accumulation of a substantial endowment fund. From the Report for the year 1904, issued a few days since by the society, we learn that a sum of £2,000 comes under the heading of investments, and of that sum £1,000 has been added during the year under review. It needs no argument to prove that the stability of the Union will be proportionately increased by every addition to its reserves. Perhaps one of the most useful outcomes of the work hitherto accomplished by the Union has been the education of the medical profession as a whole as to the imperative necessity of organised defence, both individually and collectively. The gradual evolution of this idea has involved a division of labour whereby individual defence is made the main aim and object of the Medical Defence Union, and collective defence that of the British Medical Association. At the same time it is impossible to draw a hard-and-fast line, and it is obvious that a good deal of overlapping must take place in the work of the two bodies in question. The exposure of impersonation, for instance, is clearly a general question, but it certainly would not be undertaken by the British Medical Association. The Defence Union, on the other hand, has taken the matter up, and has investigated an extraordinary case of alleged impersonation at a great cost of labour, time, and money. The result

furnishes a sarcastic comment on the feebleness and indifference of the General Medical Council, the defectiveness of the Medical Acts, and the absence of statutory and administrative protection of the rights of the medical profession. It seems incredible that the evidence so laboriously collected by the Union as to the existence of a gross fraud failed to secure a prosecution. Yet we are told that no such legal step has been taken either by the General Medical Council or by the Public Prosecutor. The Medical Council considered it a matter for the police authorities, while the Home Office held it to be the business of the General Medical Council. While the Titus Barnacles of the Circumlocution Offices are thus fulfilling their sacred duty of shirking to the utmost of their power all duty and responsibility, the community is saddled with a host of quacks, who fleece the public and defraud an honourable profession of its legitimate dues. Well may we demand a root-and-branch reform of the General Medical Council first, and of the Medical Acts next. The Report of the Union urges that every medical man should help onward the Parliamentary Committee work of the British Medical Association to the best of his power. Another instance of overlapping, which, however, is by no means a matter for regret, is the action of the Union in dealing with the Westminster coroner, Mr. Troutbeck, whose chief object in life seems to have been for the past few years to heap indignities and injury upon the medical profession of his district. As to the special defence work of the Society, little need here be said. The records of its patient, skilful, and laborious ministrations may be found in nineteen annual reports. One fact may perhaps be noted. During the past nine years, 383 cases have been undertaken on behalf of members, and in three only have adverse verdicts resulted. That record we venture to say is monumental in the annals of public societies. At this time of day it seems hardly necessary to conclude with the remark that it is the plain, simple, and bounden duty of every medical man to belong to one of the defence associations.

SEAT OF INFECTION IN TUBERCLE.

THE main problem in the pathology of tuberculosis at the present day is not so much that propounded by Koch a few years ago as to the relations existing between human and bovine tuberculosis, as a wider one to which that has led. It is, in fact, to discover by what paths the bacillus most commonly enters the body, and by this the truth of Koch's theory must ultimately be settled. The difficulties in the way are great, for neither clinical observation, however accurate, nor anatomical investigation, however thorough, can separately or conjointly give an answer. From clinical observation but little information can be gained, as we have no justification for assuming that the lesion which first gives rise to symptoms is the primary one. A comparatively small lesion in one situation may

attract notice much earlier than a large one elsewhere, and it rarely happens that one can trace with accuracy the actual moment and circumstances of infection. In most cases there is a considerable interval between the occurrence of infection and the appearance of symptoms, and we have nothing to guide us in deciding whether the disease has spread from a focus long latent or is of comparatively recent origin. It used to be assumed in support of the anatomic method of investigation, that the largest lesion marked the seat of earliest infection, but for such a view no justification can be found. It is certain that the resistant powers of the body vary in different regions, and consequently, pathologic changes take place much more rapidly in one region than in another. Moreover, the complexity of the question is increased by the discovery that the bacilli can enter the tissues without producing recognisable changes at the site of entry, and that consequently one may have marked tuberculosis without anything to point to the lungs or the intestines as the primary seat of infection. Thus, when guinea-pigs are fed on tubercle bacilli, they may develop wide-spread tuberculosis without any discoverable lesion of the mucous surface. Obviously, it is quite impossible to tell with what frequency tubercle occurs in this way in the human subject. It has been shown, too, that tuberculous bacilli in virulent condition may be present in the lymph glands or elsewhere in the body without any microscopic changes taking place. For instance, in Weichelsbaum's laboratory, portions of the tonsils, cervical, mediastinal, and mesenteric glands of children dead of acute diseases and free from all evidence of tubercle, were investigated microscopically, and by inoculation of animals. In several cases inoculation gave proof of the presence of live tubercle bacilli, where nothing abnormal was discovered by the microscope. Bearing these facts in mind, Wassermann has urged the possibility of apical phthisis being started by a tonsillar infection reaching the summit of the pleura by a lymphatic route. He points to the occurrence of pains about the clavicle and shoulder, occurring before any physical signs are to be detected, as clinical symptoms of an apical pleuritis arising in this way prior to involvement of the lung itself. The whole question is one not merely of scientific interest, but of the most far-reaching practical import, as on the solution of it must depend all schemes of prevention against the disease. Unfortunately with our present means of inquiry, there seems to be but little progress towards a solution.

HOME AND FOREIGN SPAS.

THE recent visit of British medical men to Paris was followed, in the case of those delegates who could spare the time, by delightful trips to some of the chief spas and watering-places in France. From the accounts that they have brought home there is no doubt that the delegates were entertained very handsomely, and that

every creature comfort was anticipated and provided by the generosity of their hosts. We understand that it was specially desired that there should be no suspicion that this cheerful addendum to the more official part of the programme was other than a means of showing honour to the guests of the hour, and such we readily believe. But it cannot but have brought to the minds of many of the travellers the reflection that the catering for, and treatment of, patients who visit the spas abroad is much more carefully attended to than in this country, at any rate till within the last few years. Here is a specific case where the enterprise of Continental municipalities has succeeded, under circumstances of no particular advantage, in attracting crowds of foreigners to their health-resorts, whilst our own spa authorities not only fail to "tap" the Continental invalid, but annually witness the humiliating spectacle of British wealth and fashion jostling each other in an endeavour to recuperate at a convenient distance from native springs and baths. Even the most ardent tariff-reformer would hardly propose to bolster up the spa business by levying an export tax on gouty earls and *bon-vivant* stockbrokers who go to Marienbad and Aix rather than to Harrogate and Cheltenham; and the less severe measure of retaliation would itself stand but a poor chance of success, for foreigners who seek health at British spas are as rare as a white blackbird. In all seriousness, we wonder why it is that a determined effort is not made at home to "capture" this invalid traffic, which in a few weeks annually takes to foreign lands sufficient coin of the realm practically to support a mass of hotel-keepers, servants, and attendants for the remainder of the year. The spa authorities often say that the doctors are to blame for recommending foreign resorts to their patients, whilst the doctors reply that the spa authorities have not brought their business to the pitch of excellence at which the foreign spas have arrived, and that, till the attractions are at least as great at home as abroad, it is useless to recommend British spas to those who can afford to travel abroad. The real fact would seem to be that owing to earlier and better organisation the foreign health resorts succeeded in attracting the tide of custom and fashion, and that for the British spa to succeed in diverting this, it must display over a long period an amount of energy and enterprise that has been conspicuously lacking in the past. Now, although it cannot be claimed that the British spas hold in respect to their rivals the same enviable position that the rivers of Damascus did to the Jordan, yet they are not in any way inferior to them in natural resources. There is, we believe, no character of spring, no system of treatment and no machinery of therapeutics that cannot be found within our shores, and it is hard to believe that the vagaries of the British climate are not at least equally matched at all or most of the *bads*. From the point of view of rational treatment, it cannot be maintained

that any particular virtue resides in the particular combination of natural salts to be found in any individual spring, but whether it be the sulphates, chlorides, or carbonates that are indicated, there is an almost endless variety to be obtained at different places in England or Wales. Only they are not hedged about with the magic that surrounds them when drawn from the springs of Germany or France. It is amusing to consider how much sodium chloride is annually imported into England from Hamburg or Wiesbaden, and how much sodium sulphate from Karlsbad or Marienbad, as though these salts were unobtainable in any other way. But if the British spa is to become anything but the poor handmaiden of her foreign rivals, it is necessary that two cardinal points should be grasped. The first is that medical men should be made fully aware of all the advantages and appliances available at home spas. We venture to assert that for each *brochure* sent out from an English health resort, fifty are issued by obscure spas in the fastnesses of Bohemia or Italy, and it is actually the fact that medical men as a whole are far better acquainted with the properties of the waters and baths of the inland watering places of the Continent than with those of their own country. The second, and no less important, point is that the methods of the Germans, which in particular have proved so successful, should be adopted—the methods of quietly but firmly managing the patients who come as visitors, so that they feel their own wills superseded for the time being and their "cure" regulated for them. The bulk of sufferers who repair to the Continent are those who have been doing a little too much eating and drinking, and what they require is a system of discipline under which they may recover the tone of their nervous and digestive systems. Nothing is better for the former than a little rest, nor for the latter than a mildly depletory water. Both are to be obtained within the circle of our coasts.

Notes on Current Topics.

Handwriting and the Visual Field.

THAT serious defects of vision are sometimes induced and often aggravated by the act of writing will be universally admitted. The ordinary attitude assumed by children when learning to write is more harmful, physically, than that adopted while reading. Attention has hitherto been practically confined to the latter. Dr. George M. Gould, of Philadelphia, that apostle of eye-strain, believes that "the act of writing, as commonly carried out, is wholly wrong all the time." He points out that slanting writing is neither beautiful nor rational, it being an outcome of a bending of the head to the left or screwing the paper round, in order that both eyes may have a clear view of the visual field. The partial eclipse of the visual field by the pen itself or the finger-tips is held to be responsible for the increased strain thus placed upon the organs of vision, so that a sloping cali-

graphy is inevitable. The analogy is drawn between the various printed signs, such as type-writing, printing, and musical notes, all of which preserve their upright character. The artist overcomes the difficulty by using a long brush, so that his visual field is obscured as little as possible. Vertical handwriting, though still disdained by some as being "too modern," has, nevertheless, the advantage over the older sloping form of not causing the writer to obscure his own visual field by the necessary posture of hand and pen. A tendency to eye-strain and consequent fatigue is, therefore, somewhat obviated, but in addition to observing these precautions it is also important that the slope of the desk should be physiologically correct. The majority of school-desks are not inclined nearly enough, and various cramping postures are only too frequently assumed by pupils of all ages. There is yet much room for improvement in this department of school hygiene.

The Midwives Act—Medical Assistance to Midwives.

THE following extract from the *Local Government Chronicle* of May 27th is of importance to the medical profession:—"By Article 17 of the rules of the Central Midwives Board, regulating, supervising, and restricting within due limits the practice of midwives, it is required that in all cases of abortion, of illness of the patient or child, or of any abnormality occurring during pregnancy, labour, or lying-in, a midwife must decline to attend alone, and must advise that a registered medical practitioner be sent for. Inquiry was made of the Local Government Board as to whether the Public Health Act or any other Act authorises local authorities to pay fees to medical men when so summoned to the assistance of midwives, and the Board stated that it seemed to them that if a town council or other local authority (*i.e.*, urban district council or rural district council) for the execution of the Public Health Act, 1875 (38 & 39 Vict., c. 55), are willing to pay for the medical assistance required, the provisions in Section 133 of that Act might possibly be available. On the other hand, a case of the kind might conceivably come within Section 2 of the Poor-law Amendment Act, 1848 (11 & 12 Vict., c. 110), and the Guardians might then, if they wished, pay for the medical assistance required. [Section 133 of the Public Health Act, 1875, enables a local authority, with the sanction of the Local Government Board, to themselves provide or contract with any person to provide, a temporary supply of medicine and medical assistance for the poorer inhabitants of their district, and Section 2 of the Poor-law Amendment Act, 1848, makes provision for medical assistance being rendered in cases of sudden and urgent necessity without an order having been previously obtained from Guardians or their officers or from the overseers.]"

Digestive Preparations.

A PAPER of great significance was published in the *Boston Medical and Surgical Journal* of May 18th by Dr. Richard F. Chase. Dr. Chase holds very sceptical views as to the value of digestive preparations in diseases of the stomach, and after instituting a series of experiments he arrived at results which he does not hesitate to announce in emphatic language. Briefly stated, these are that as pepsin can only act in a properly acid medium, it is therefore useless to give preparations that depend on pepsin as the active ingredient, unless the juices of the stomach are of the appropriate degree of acidity. Now in ninety per cent. of gastric disorders, either HCl is present, and with it sufficient pepsin to accomplish digestion—in which case any addition of pepsin is superfluous—or HCl is deficient and during this deficiency it is impossible for pepsin, naturally produced or artificially administered, properly to act. Moreover, in the latter case, if the HCl be increased, the natural pepsin immediately becomes active. Now it is impossible to prepare any combination of HCl and pepsin of sufficient stability to enable it to be put on the market, and equally it is impossible for pancreatic preparations to act in other than an alkaline medium. Dr. Chase also states that it is not possible practically to administer HCl in such a quantity as that the percentage present in the gastric contents shall be that in which pepsin is active, namely, .2 to .25 per cent. He falls back, therefore on the conclusion that the successful treatment of gastric affections consists in stimulating the functions of the stomach, and not in attempting to supersede or reinforce its secretions with artificial preparations.

Transactions of the "Med.-Chi."

IN this, the centenary year of the Medico-Chirurgical Society, it is of much interest to notice the important papers that have appeared in its *Transactions*, and almost equally interesting to notice those that were denied that distinction. In the first volume may be found the record of Sir Astley-Cooper's first case of ligature of the carotid, and in one a little later a paper by Dr. Wardrop advocating that patients should be bled to the point of insensibility before operation, so that the surgeon might do his work without inflicting pain. Marshall Hall, a vigorous opponent of bleeding, recorded his work on reflex action in the *Transactions*, and was much scoffed at by his contemporaries for that enunciation of such fanciful notions. Jenner, the discoverer of vaccination, read papers to the Society; Spencer Wells preached ovariectomy to his fellow-members; Henry Thompson discoursed on operations for stone in the bladder; Brodie recorded his important studies on the diseases of bones and joints; Kirkes announced his discovery of embolism; Marcet, his successful inoculation of animals with phthisical sputum; and many modern heroes of medicine, whose names are too numerous to mention individually, chose the

Society as their audience when bringing forward fresh advances in medicine and surgery. Besides Marshall Hall, Addison and Bright were both regarded somewhat askance by the orthodox members of the "Med.-Chi." of their day, and Forbes, who first introduced the stethoscope to the Society's notice, was not accorded even the courtesy of publication in the *Transactions*.

School Dentists.

At the recent conference of the British Dental Association, at Southport, an important paper was read by Dr. Norman Bennett on "School Dentistry." The paper had been prepared in response to an invitation from the School Dentists' Society, which is an offshoot of the British Dental Association. Dr. Bennett's arguments were directed to prove the usefulness of the dentist as a functionary of the elementary school, not only for the repair of bad teeth but for the prevention of dental disease. He spoke of the unfed children question and pointed out that it was but a poor policy to provide children with food unless they had teeth wherewith to chew it, and defective teeth were only too common among children of the elementary schools. He explained the aims of the School Dentists' Society to be the introduction of teaching in dental hygiene, the instruction of teachers themselves in the same subject, and the provision of dental inspection and treatment in schools. In the discussion that followed several medical men and dentists took part, all of them speaking in favour of the proposal. Dr. Miller, of Berlin, made the emphatic statement that there was scarcely a disease that could not be brought about through a diseased condition of the mouth, and we fancy that most medical men will not quarrel with the assertion. The importance of the school dentist as a factor in preserving the national health has been frequently insisted upon in these columns, and we are glad to see Dr. Bennett's paper being widely quoted in the press. Before any practical steps are taken, it will be necessary to form public opinion in favour of the dentist, and to do so will be an arduous task, but one of profound utility to the future of the country.

Tramps and Small-pox.

THE tramp is probably the most potent individual agent in the spread of small-pox, a fact often brought out in the reports of medical officers of health, and much insisted upon at the official conference on the tramp and his management. The general recognition of this agency has led to a good deal more watchfulness on the part of authorities, and it is pleasing to read in Dr. Pilkington's annual report on the health of Preston that during the outbreak of small-pox in that town there were remarkably few cases admitted from the casual wards and common lodging-houses. This is attributed to the amount of vaccination and re-vaccination that has been carried out of late years, and it is satisfactory to note that what might have become an alarming

epidemic was so far kept within bounds that not a hundred cases occurred in all. On the other hand, one district does not seem to be a rule for another, for in the annual report of Dr. John Hogg, medical officer of the Shardlow Union, he states that a case of small-pox was discovered in a tramp-ward of the workhouse, and the sufferer removed to hospital. Vaccination was offered to the other occupants, but was universally refused, because, in Dr. Hogg's opinion, the men prefer to have small-pox and be nursed in the comparative luxury of an isolation hospital, to tramping about the country with a sore arm. One naturally looks for the unmasked elementary passions of human nature among the poor and outcast members of society, but there is a selfish cynicism about the view that suggests its own remedy.

The General Medical Council and Dental Diplomas.

At the recent meeting of the General Medical Council it was decided to accept, for purposes of registration upon the "Dentists' Register," the licence in dental surgery of the University of Dublin and of the Victoria University of Manchester. It was further decided that the degrees in dental surgery and science of the same Universities be recognised for entry upon the "Dentists' Register" as additional diplomas, memberships, licences, etc., granted in respect of a higher degree of knowledge.

Illness in Parliament.

HARDLY any session of Parliament passes without some case of death or grave illness arising within the walls of the two Houses, and of minor accidents and emergencies there are always a number. Indeed, the normal of such occurrences must reach a high level when nearly a thousand men, most of them over middle age, are daily congregated together for many hours in a few rooms. It is perhaps significant of the conservatism of the British institution that no means should exist for coping with such emergencies beyond appealing to the humanitarian instincts of such medical members of Parliament as may happen to be in the House. Incidentally, it may be remarked that the advice given at such times is as studiously followed as it is studiously ignored when given in the course of debate in the adjoining Chamber. In reply to a recent question in the House, the First Commissioner of Works furnished the information that, with a view to meeting medical emergencies, telephonic communication was about to be established with Westminster Hospital—the institution that is usually called upon to assist at such times, but that whether any subscription should be made to the hospital in return for its services was a matter for the Treasury. Since the Houses of Parliament, in the persons of their members, represent the wealth of the country to at least the same extent as its intellect, it is almost inconceivable that such meanness should be exhibited. The Westminster

Hospital is not well off, and is supported by charitable people for the relief of the sick poor, not for the accommodation of wealthy merchants and landowners. To expect the hospital to succour such in the event of illness—with or without a money contribution—is not only a diversion of the functions of the institution, but sets a glaringly bad example to the rest of the community. There is no reason why the Houses of Parliament should not have a properly-equipped medical department, and taxpayers would not grudge their representatives the comfort and relief it would afford them.

The Leviathan of Consumption.

THE outcry against the use of the flesh of vaccinated calves for purposes of human food appears to be a subtle device of the anti-vaccinationists by way of discrediting the enemy at any cost. What does it all mean? The calf is inoculated with a particular micro-organism which, passing through its system, is so profoundly modified in its nature that when implanted in man by subsequent vaccination it protects him against the ravages of a deadly disease—to wit, small-pox. The effects of the inoculation of the calf are fleeting. A month or so after the process the calf is healthy, and there is nothing to show that its flesh cannot be eaten with impunity. Were it otherwise, the fact would long since have been recognised by medical science, and sanitarians would have forbidden butchers to send the flesh of vaccinated calves to market. The outcry against the use of what the anti-vaccinationists love to describe as "vaccinated veal" is clearly based on sentimental objection, otherwise, in plainer phrase, on plain unreasoning prejudice. There are plenty of deadly diseases such as consumption, anthrax, and various parasites, which, unlike fleeting small-pox, remain permanently active in the tissues of cows, sheep, and other lower animals used for food, and these are probably the cause of a vast amount of disease, suffering, and death. Why should the anti-vaccinationists strain after the camel of vaccination while they swallow the leviathan of consumption with unheeding maw?

The Medical Botanist and Lobelia.

A MOST amusing correspondence has been going on in the *Manchester Evening Chronicle* on the "Use of Lobelia." A number of medical botanists have been laying down the law with regard to that plant with a dogmatism that is absolutely refreshing after the guarded conclusions advanced by medical investigators of the mysteries of *materia medica*. There can be no more complex study than that of the physiological and therapeutic uses of plants, involving as it does, a profound knowledge of the technical process of the modern chemical laboratory as well as of the action of the human body in health and in disease. The net result of medical science so far as lobelia is concerned is to recognise it as possessing

potent properties of so uncertain and dangerous a nature as to render it of little use in practical medicine. Not so the herbalists. One gentleman on his honour as a medical botanist of over twenty-five years' experience, assures us that lobelia, when made with vinegar or water, is perfectly safe for all ages. Another offers to drink a quarter of a gill to prove it is not poisonous. A third, on the other hand, quotes Dr. Coffin's M.D., "Botanic Guide to Health," to show that lobelia, although one of the most powerful stimulants that can be introduced into the human system, can nevertheless be given with success in almost any form of disease, from the tender infant to the aged bending under the weight of years. Yet another says he has drunk lobelia for twenty years as herb beer and herb tea, and knows a firm that has sold at least a hundred pounds weight per year for the last forty years. If this be the case, it suggests the urgent need of a Government inquiry into the methods of medical herbalists, botanists, and makers of so-called medicinal beverages. It is out of touch with the scientific spirit of the age that deadly drugs, or, for that matter, drugs of any kind, should be sold by medically unqualified persons for the treatment of disease.

The Royal College of Surgeons and the Irish Medical Association.

THE President of the Royal College of Surgeons in Ireland in the course of his annual address at the meeting of Fellows, devoted a large part of the time at his disposal to the consideration of Surgeon-General Evatt's attack upon the Colleges, and to the attitude adopted on that occasion by the Irish Medical Association. Did space permit, we should like to publish his remarks *in extenso*, as they are so entirely appropriate. Mr. Chance detailed the circumstances under which Surgeon-General Evatt was entrusted with his commission, and related again how in consequence of a breach of trust on the part of an officer or servant of the Association a confidential report was communicated to the Press. He then read in full the correspondence which had passed between the College and Council of the Association, and showed how incorrect was the statement that the College had dictated or in any way indirectly influenced the Council of the Association in order to compel it to pass its resolution dissociating itself from Surgeon-General Evatt's attack. We agree entirely with Mr. Chance when he says that the Council of the Association, having repudiated this portion of the report, has not shown equal wisdom in persisting in regarding the report as a whole as still confidential. The Colleges, he says, should be, and are, open to criticism, but such criticism should be fair and open. While, however, the report as a whole is kept confidential, "we are debarred from dealing with criticism which we know to be offensive and believe to be undeserved." Apart entirely from the question of fair treatment of the criticised bodies, we suggest

to the Association that it is doing itself a grievous injury by still regarding the report as confidential. Rightly or wrongly, an impression has been created that the true reason why secrecy is continued is not, as has been said, out of consideration for the feelings of the Colleges, but in order to prevent Surgeon-General Evatt's criticism of the present management and of the officers of the Association from becoming public. We commend to those gentlemen to whom the present unfortunate position of the Association is largely due an article which appears in the columns of the daily Press on the Irish Medical Association. The writer knows what he speaks of, and utters his opinions without fear. We share his fears with regard to the future of the Association; but at the same time we hold the belief that it still possesses members who, if they unite their efforts, are capable of restoring the Association to its proper position, and prominent amongst these we place Mr. Chance, the President of the College of Surgeons.

Protection Against X-rays.

THE somewhat sensational reports which have appeared both in the medical and lay press within the past few years regarding the risks attached to constant working with X-rays, have naturally turned the attention of operators to the best methods of self-protection. As indubitably the rays may and commonly do cause serious and persistent dermatitis, and as they have been credited with the percentage of most of the ills to which flesh is heir, from cancer to sterility, it is right that every precaution should be adopted by those who in the routine of their daily work are most exposed to danger. Dr. Charles Leonard, of Philadelphia, himself an operator of wide experience, has, in a recent paper (a), detailed the measures he regards as advisable in guarding against injury by X-rays. He has devised a very simple contrivance for limiting the irradiated field to the part of the patient required. This is simply a pasteboard box covered loosely with a curtain of lead foil; a heavier foil than tea-lead is advisable, though a double thickness of the latter is probably quite effective. The ends being removed from the box, the tube is placed in it, and rubber bands or string keep it sufficiently firm. If a fluoroscope is to be used, the operator should stand behind a thick lead screen, and the screen of the fluoroscope should be covered by a sheet of quarter-inch plate glass. As it is probable that high induction coils have an injurious effect on cell metabolism, Dr. Leonard advises that all induction coils should be in a neighbouring room, wires being led into the operating room through porcelain tubes. By such simple measures as these, as well as by observing the obvious precaution of never exposing one's hands for the purpose of testing the fluoroscope, Dr. Leonard believes that most of the dangers incident to X-ray work may be avoided.

(a) *Journ. of the Amer. Med. Assoc.*, May 6, 1905.

PERSONAL.

THE Prince and Princess of Wales, Grand President and Lady Grand President of the League of Mercy, will receive the Presidents, Lady-Presidents, and others at the meeting of the Colonial Nursing Association to-day.

THE German Emperor has sent Lieutenant-Colonel W. G. A. Bedford, C.M.G., R.A.M.C., the officer in charge of the Military Hospital at Gibraltar, four pictures showing German Cavalry and Infantry in different periods. These are to be hung in the hospital as a souvenir of his Majesty's recent visit.

THROUGH a bequest from the late A. Ocran Crooke, electric lighting and an electric lift have been added to the Metropolitan Hospital, London.

THE Hospital for Sick Children, Great Ormond St., London, has received a parting gift of £20 from Mrs. Choate, the wife of the retiring American Ambassador. Her Excellency was much interested in the work there.

MR. OWEN and Mr. Godlee will offer themselves for re-election as members of Council of the R.C.S.E. Sir Henry Howse will not stand again. Mr. C. H. Golding-Bird, of Guy's Hospital, intends standing for one of the vacancies and Mr. Harrison Cripps, of St. Bartholomew's Hospital, is also a candidate.

PROFESSOR W. CORTE (Berlin) has been elected President of the next Berlin Surgical Congress.

THE Lord Chancellor this year accepted the invitation of the Guild of Undergraduates to become the Warden of Birmingham University.

THE President of the R.C.S.E. has selected Wednesday, July 12th, from five to seven o'clock, for the reception in the museum of the College to the members and visitors of the Atlantic Union.

A GENERAL hospital for Putney is made possible by the generosity of the late Mr. Henry Chesters, a resident who left £60,000 for that purpose to the Haberdashers' Company, on condition that the building should be commenced within twenty years of the testator's death. Failing this the money is to go to Guy's Hospital.

DR. R. DENMAN, Chief Medical Officer, Seychelles, has left the Colony on nine months' leave of absence, during which Dr. A. A. N. de Gruchy, Assistant Medical Officer, acts for him.

THE forty-fifth annual dinner of King's College, London, will be held at the Hotel Cecil on Monday, June 26th, when Colonel Richard H. Jelf, C.M.G., will take the chair. All communications should be addressed to Mr. John Chapman, honorary secretary of committee, at the College.

SURGEON-CAPTAIN THOS. E. MACKENZIE, of the Royal Army Medical Corps, has been awarded the Stanhope Gold Medal by the Royal Humane Society for the most meritorious act of heroism performed during the year. This is the seventh decoration won by Captain Mackenzie during the last six years.

MR. W. McADAM ECCLES, F.R.C.S., has been appointed Examiner in Surgery to the Society of Apothecaries, London.

THE King's County branch of the Irish Medical Association has decided to support the candidature of Sir William Thomson for the post of Direct Representative for Ireland on the General Medical Council.

MR. R. F. TOBIN, F.R.C.S., Surgeon to St. Vincent's Hospital, has been appointed Consulting Surgeon to

the Hospital for Diseases of the Skin, in Dublin, *vice* Sir Philip Crampton Smyly deceased.

THE vacant post of assistant physician at the Westminster Hospital has been allotted to Mr. Eric Macnamara, M.A., M.B., Cantab., M.R.C.P., a son of the well-known surgeon.

It is announced that Dr. Farquharson, M.P., who has so long represented West Aberdeenshire, in the House of Commons, will not seek re-election for that division, owing to the state of his health.

SIR ALFRED COOPER has intimated his desire to vacate his seat as a Member of Council of the Royal College of Surgeons of England at the coming election in July.

Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

EDINBURGH.

THE CHAIR OF MIDWIFERY, UNIVERSITY OF EDINBURGH.—Although not officially announced, it is understood that the Professorship of Midwifery in the University of Edinburgh will shortly be vacant through the resignation of Professor Simpson, who contemplates retiring on the completion of thirty-five years' work. Notwithstanding his long services, Professor Simpson is full of vigour and activity, and as Emeritus Professor we trust that his counsel will long be at the disposal of the University. The present would seem a most suitable time for subdividing the chair which he has for many years adorned. Midwifery, the diseases of women and the diseases of children, keeping in view the immense advances made in each of these departments, can no longer be taught as they should be by any one man. For practical purposes the instruction in diseases of children which the Edinburgh student receives, or now got, was not in the midwifery class-room, but in the Sick Children's Hospital, so that the divorce has already been accomplished. It is to be hoped that arrangements will be made for teaching obstetrics and gynaecology separately, by founding a lectureship, at least, on the latter subject. The professor of midwifery would continue to retain the clinical appointment in the maternity hospital, while the gynaecological ward which the holder of the chair now has in the infirmary would be placed at the disposal of the teacher of diseases of women.

ROYAL VICTORIA HOSPITAL FOR CONSUMPTION, EDINBURGH.—The annual general meeting of this hospital took place on May 31st, speeches being delivered on the occasion by Lord Aberdeen, Professor Chiene, Dr. Playfair, President of the Royal College of Physicians, and others. Eighteen months trial of the new buildings has fully justified the sanguine expectations formed at their opening by Lord Rosebery in 1903, since which time they have been inspected by many visitors and deputations, whose criticism has been uniformly one of admiration. The plan, as drafted by the architects, provides for sixty-eight beds more than those now existing, and it is hoped that, by a great fancy fair to be held next winter, enough money may be raised to provide this extension. Professor Chiene, in seconding the adoption of the report, commended the admission of contributing patients. There were many people coming to the Royal Infirmary who should not go there, and this particularly in the surgical department. He cordially supported the idea of an "after care" colony, and lauded the educational influence of an institution like the Victoria Hospital upon the community. There should be a rule that nobody should be admitted who had been for more than six months ill with the disease; so long as they had the tubercle bacillus alone much could be done; with mixed infection the chance was not nearly so good. In conclusion, he urged on the wealthy the need for having a pavilion for surgical tuberculosis. The erection of such would be a boon to suffering humanity. A resolution enforcing the necessity for such hospitals and the duty of the public in maintaining them, was

moved by Dr. Playfair, who dwelt on the hopeful outlook as regards the treatment of tuberculosis now compared with that of twenty years ago. Even within the last ten years the mortality in Edinburgh had fallen more than that of fevers. An "after cure" colony would greatly relieve the anxiety of those in charge of sanatoria as to the progress of patients discharged apparently cured. These were not always fit to return to everyday life and work, and what was wanted was a place in the country where healthy outdoor work would drive away the last seeds of disease and brace the system to resist any further attack.

BELFAST.

FEVER EPIDEMIC AT NEWTOWNARDS.—The prosperous little town of Newtownards, in Co. Down, is at present suffering from a rather severe epidemic of typhoid and scarlatina. The population of the town is 9,000, and last week there were in the fever hospital forty-seven patients, thirty-five of whom were suffering from typhoid, and twelve from scarlatina. Three cases of diphtheria had to be taken to the infirmary and isolated there, as the fever hospital was full. The typhoid is said to be lessening, but the scarlatina is increasing in amount, and Dr. Clibborn, the Local Government Board inspector, has had a consultation with the guardians with a view to providing further accommodation. As usual, the epidemic will probably be a blessing in disguise, for it is well known that part of the water supply is bad, and the drainage not above suspicion.

INSPECTION OF MEAT.—The municipal authorities have taken a step which may lead to much good in sending two of their officials to visit certain cities on the Continent to see the most approved methods of inspecting public abattoirs and stamping meat. They have handed in a report, which is to be printed and supplied to each member of the Corporation, so that the whole subject may be considered at their next meeting. If the first step is followed up it will be an excellent thing for the city.

APPOINTMENT OF PHYSICIAN TO THE NEW FEVER HOSPITAL.—A matter of considerable interest was discussed at the meeting of the Belfast Corporation on June 1st. The Health Committee of the Corporation recommended that Dr. Gardner Bobb should be appointed visiting physician to the new fever hospital at a salary of £400 per annum after the hospital is open, and meantime that he should receive £100 per annum, and act as expert adviser on matters connected with the building and equipment of the hospital. Though no mention is made of the fact in the papers, it is said that there is to be an understanding that Dr. Robb should retire from general practice, and only act as a consultant in fever cases. The arrangement was sanctioned by the Corporation, but not until it had been subjected to sharp criticism. It was said that, owing to the long distance from the city at which the new hospital is situated, it will be necessary to have an experienced resident physician, and, if so, the proposed salary for a visiting physician is too high. In Edinburgh, for instance, the highest payment to the visiting physician is £200 per annum. Besides this, Dr. Bobb receives £170 per annum as visiting physician to the fever hospital at the workhouse, and no arrangement has been made as to the possible interference of the two posts. When questioned, the chairman of the Public Health Committee simply said that the Corporation had nothing to do with the Guardians, which is no doubt true, but he forgot that there is this intimate relationship—that both bodies are engaged in spending the ratepayers' money. Notice has been given that the whole matter will be brought up at a future date, and the question re-opened. The right and sensible plan would be to appoint Dr. Robb as resident physician, not visiting, with a house and proper salary.

QUEEN'S COLLEGE, BELFAST.—A meeting of the subscribers to the Better Equipment Fund of the College was held on the 2nd inst., and a report presented. About £30,000 has been raised and applied to various pressing needs, some of the most important being in the medical school. The Musgrave Chai

of Pathology has been founded, the Riddell demonstratorship in the same subject, a biological laboratory is being built, and the museums and laboratories generally improved. Of course much remains to be done, but the record is not a bad one as an example of self-help, when no help was forthcoming from Government.

Correspondence.

"IRISH MEDICAL DIRECTORY."

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Great indignation has been aroused in the profession at the boycotting tactics displayed in the above precious publication. It may not be generally known, however, that this is not the only form of boycotting indulged in by the I.M.A.

Three years ago I received a circular from the local branch of the I.M.A., inviting me to become a member. In response I sent a cheque as my subscription, with the request that my name be enrolled on the list of members. The local secretary, in reply, returned my cheque with a curt intimation that the circular had been sent me by *mistake*. This was the only reason assigned for the insulting manner in which my application was received.

It would be interesting to know how many members of the profession, whose names do not appear in the "Directory," have been similarly treated.

I am, sir, yours truly,

June 2nd, 1905.

ENQUIRER.

THE KING'S FUND AND THE MANAGEMENT OF HOSPITALS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The letter of "M. D.," in your issue of May 31st invites further comment in the interests of fair play.

It seems to me—as an unprejudiced onlooker—that the King Edward's Fund has placed itself hopelessly out of court in suggesting the Queen's Jubilee Hospital should be handed over to the Fund's management for a year, the honorary staff and the Hospital Board of management having just resigned. What powers have the Fund to become hospital managers? Money is handed to them as a distributing trust agency, and the governors of a hospital are the only persons legally entitled to control the government of their institution. It is not possible for any executive to hand over their institution without the express consent and direction of the governors. And yet one of the King Edward's Fund commissioners was a lawyer!

I am, sir, yours faithfully,

London, June 1st, 1905.

ONLOOKER.

THE TROUTBECK INQUEST ON THE MASKED MURDERERS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I am glad your correspondent "Observer" has drawn attention to the fact that the sworn foe of our profession, Mr. Coroner Troutbeck, called in Dr. Freyberger to make a *post-mortem* examination on the murderers Stratton after their execution in Wandsworth Gaol. Now, sir, one of this eccentric coroner's public excuses is that he wishes to save the ratepayers' pockets. Yet that *post-mortem* examination was absolutely superfluous. The evidence of the executioner and of the Medical Officer of the prison would surely afford sufficiently explicit and conclusive proof of the cause of death. Even were a *post-mortem* needed, why should not Dr. Beamish, the prison medical officer, as your correspondent asks, have performed it?

The medical men of the Westminster district have at length united in offering a firm resistance to the injurious proceedings of Mr. Troutbeck. His misguided and unjust line of conduct has, happily, not been adopted by his brother coroners of London and elsewhere, who are, as a body, distinguished by their common sense, their tactfulness, and their desire to carry out the duties of their office *sans peur et sans reproche*. For all that it is necessary to nip this evil weed of Trout-

beckism in the bud. The medical profession is indebted to you, sir, for the manly and outspoken way in which THE MEDICAL PRESS AND CIRCULAR has from the first exposed the unfairness of this Westminster simpleton.

I am, sir, yours faithfully,

CIVIS LONDINIENSIS.

Westminster, June, 1905.

Obituary.

EUSTACE TALBOT, M.B., B.C.CANTAB., M.R.C.P. LOND.

WE regret to record the death from appendicitis of Dr. Eustace Talbot. He was in his usual health and at work as late as May 18th, but became rapidly ill, and an operation was performed on May 21st. On the afternoon of the 25th he became much worse, and died a few hours later. He qualified in 1899, and was soon appointed resident medical officer at the Royal Hospital for Diseases of the Chest, afterwards becoming house physician at St. Bartholomew's. He took his M.R.C.P. in 1901, and although obliged to spend part of his winter at Davos, he worked most energetically and capably while in London, and was highly popular as a confrere and friend in the medical and lay world.

GEORGE STAMP TAYLOR, M.R.C.S.Eng., L.R.C.P. EDIN.

THE death of Mr. George Stamp Taylor, M.R.C.S., which took place at his residence, Clifton House, Beeston Hill, will occasion sincere regret alike amongst members of the medical profession in Leeds and the public generally in Hunslet and Holbeck. Dr. Taylor was one of the best-known and most highly respected general practitioners in the city; and he was particularly well-known to the industrial classes, his club practice in connection with the friendly societies being one of the largest in Leeds. His death has occurred at the comparatively early age of fifty-eight, after a practice in his profession extending over thirty-five years. Dr. Taylor was a native of Acomb, near York, the son of Mr. Isaac Taylor, of Grove House. He was a student of the old Leeds Medical School, and was elected a member of the Royal College of Surgeons (England) in 1870, subsequently taking the degrees of L.R.C.P. and L.M. at Edinburgh University. Prior to this he was a resident surgeon at the Leeds Infirmary the Institution being removed from Infirmary Street to its present site during his term of office. After some experience in Burmantofts as assistant to Dr. Joseph Holmes, he commenced practice in Meadow Lane exactly thirty-five years ago.

Medical News.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

AN ordinary meeting of the Council was held at the College on Thursday, the 1st inst., Mr. John Tweedy, President, in the chair.

The following members of the College, having passed the required examinations and conformed to the by-laws, were admitted Fellows of the College:—Frank Arthur Sreat, L.S.A.Lond., St. Barts; Frederick Norman, L.R.C.P.Lond., St. Barts; William Selby, D.S.O., Capt. I.M.S., L.R.C.P.Lond., St. Barts; Thomas Howard Foulkes, Capt. I.M.S., L.R.C.P.Lond., St. Barts.; Jas. Middleton Graham Swainson, L.R.C.P.Lond., Westminster; Thomas Perrin, M.B.Lond., St. Thos. and Lond.; Edgar Taunton, M.B.Lond., Univ. Coll. and Lond.; Charles Bertram Thompson, L.R.C.P.Lond., Guy's and Lond.; Robert Alex. Walker, M.B.Cantab., St. Geo. and St. Barts.; Charles Killick, M.B.Cantab., St. Mary's; Cecil Irving Graham, L.R.C.P.Lond., St. Mary's; Charles Ernest Lakin, M.D.Lond., Middlesex; Robert Valentine Dolbey, M.B.Lond.; Geo. Fredk. Darwall Smith, M.B. Oxon., St. Geo. and Oxford; Owen Wm. Richards, M.D.Oxon., Guy's and Oxford; Harry Pier point, L.R.C.P.Lond., Liverpool; Bernard Joseph

Ward, L.R.C.P.Lond., Birm. and Lond.; Moses Thos. Williams, M.B.Lond.; Wm. Warwick James, M.R.C.P.Lond., Middlesex; Oliver Francis Haynes Atkey, M.B.Lond., King's Coll.; Walter Leigh Mackinnon Goldie, L.R.C.P.Lond., Edin. and St. Mary's; Thomas Guthrie, M.B.Cantab., St. Thos.; Henry Bailey Mylvaganam, L.R.C.P.Lond., Ceylon and St. Barts.; Arthur Francis Hamilton, M.D.Lond., St. Barts.; Francis Seymour Kidd, M.B. Cantab., Lond. and Camb.; Leonard Moon, L.R.C.P. Lond., Camb. and St. Barts.; James Douglas Cooke, M.B.Melb., Lond. and Melb.; Arthur Cyril Hudson, M.B.Cantab., St. Thos. and Camb.; Fredc. Wm. Daniels, L.R.C.P.Lond.; Tom Bates, L.R.C.P.Lond., St. Barts.; Thos. Bonhote Henderson, M.B.Oxon., St. Thos. and Oxford; Sydney Chalmers Allen, M.D.New Zeal., Lond. and New Zeal. The following not being members of the College, were also admitted Fellows:—John Dundon, M.B.R.U.I. Queen's Coll., Cork; Fredk. Wm. Ellis, M.D.Aberd., Aberd, Leeds, and King's College; Edgar Montagu Pilcher, D.S.O., Major R.A.M.C., M.B.Cantab., Guy's.

Licences in Dental Surgery were granted to the following candidates:—Francis Leonard Aubrey, Edward Robert Barton, Albert Benjamin Cocker, Horace Chas. Colyer, Wm. Edmund Cook, Lawrence Chas. Crockett, Geo. Herbt. Curtis, Arthur John Dainty, Harold Seymour Douthwaite, Archibald Roland Durant, Theodore Jas. Gayton Fielder, Claude Rawlinson, Fitch, Arthur Alan Forty, Tom Scott Foster, Wm. Douglas Frew, Fredk. Holcombe Fuller, Robt. Gray Gillies, Francis Gordon, Walter Hargrave, Sidney Harlock, Alfred John Higson, Seth Moore Hopkinson, John Joseph Horton, Frank Alfred Husbands, Herbt. Jenning James, John Robertson Knott, Geo. Kennaway Mallory, Percy Barrett Mardon, Arthur Miller, Sydney Bullen Newton, Norman McLeod Nibbs, Harold Geo. Normandale, Arthur Wm. Parrott, Henry Garfield Pearce, Albert Pfeiffer, Percy Julian Quinton, Raniero Rotelli, Herbert Snell, Francis Radway Smyth, Henry Edward Staniforth, Hedley Hargreaves Taylor, George Gilbert Timpson, Henry John Trude, Wm. Westland Vaughan, Reg. Geo. Heegaard Warner, Ingram Ernest Watson, Douglas Geo. Wearing, Reg. Cecil Webster, Francis Raymond Wilson, Ralph Greatrex Yates.

Upon the recommendation of the Board of Examiners in Dental Surgery it was decided to recognise the Licence of the Dental Board of Victoria, and that the holders of such licence should be admitted to the First and Second Professional Examinations of the College together, without being required to pass the Preliminary Science Examination. An alteration was also made in the regulations for the Licence in Dental Surgery with a view to affording colonial and Indian graduates and licentiates the same privileges of exemption from portions of the Second Professional Examination for the licence as are accorded to British graduates and licentiates.

The President reported that he had selected Wednesday, July 12th, from 5 to 7 o'clock, for the reception in the Museum of the College of the members and visitors of the Atlantic Union.

The following examiners were elected for the ensuing collegiate year:—Board of Examiners in Anatomy and Physiology for the Fellowship—Anatomy—L. A. Dunn, Arthur Keith, Christopher Addison and W. McAdam Eccles. Physiology—E. Waymouth Reid, E. H. Starling, Leonard Hill and de Burgh Birch. Conjoint Examining Board—Elementary Biology—H. W. Iyle, Walter G. Ridewood, T. G. Stevens, and H. W. Marett Tims. Anatomy—H. J. Waring, Arthur Keith, Christopher Addison, and J. Ernest Lane. Physiology—W. H. Thompson, T. Gregor Brodie, and J. B. Leathes. Midwifery—William Duncan, J. H. Targett, G. F. Blacker, and A. H. N. Lewers. Public Health—(Part I.) A. G. R. Foulerton. (Part II.)—H. Timbrell Bulstrode.

A letter was read from Sir Alfred Cooper stating that he wished to resign his seat in the Council, as he con-

templated retiring from practice in the near future. The resignation was accepted with regret.

The President reported that a meeting of the Fellows would be held on Thursday, July 6th, for the election of four Fellows into the Council in the vacancies occasioned by the retirement in rotation of Sir Henry G. Howse, Mr. Edmund Owen, and Mr. Rickman J. Godlee, and by the resignation of Sir Alfred Cooper.

ROYAL COLLEGE OF SURGEONS, IRELAND.

THE annual meeting of the Fellows was held on Saturday last, June 3rd, Mr. Arthur Chance, President, occupied the chair. The annual report was read—showing a prosperous year. Considerable improvements were made during the year, notably a new Examination Hall was opened. A perfect system of electric lighting was laid on for the entire buildings from the Corporation supply. The Honorary Fellowship of the College was conferred on Dr. Traile, Provost of Trinity College. The Carmichael Prize Essay was awarded to Mr. M. F. Reany, the "Barker" Anatomical Prize to Mr. C. Cooper, the Mayne Scholarship to Mr. A. N. Crawford, the "Carmichael" Scholarship to Mr. J. Prendiville, the Gold Medal in Operative Surgery to Mr. J. S. Dunne, the Storey Memorial Gold Medal to Mr. J. Prendiville.

The Stanhope Gold Medal awarded by the Royal Humane Society to the person considered to have performed the most meritorious act of heroism of the year was conferred on Captain Thomas Campbell Mackenzie, D.S.O., Royal Army Medical Corps, a licentiate of the College. Six years ago Dr. Mackenzie was nominated by the College for a commission in the Royal Army Medical Corps. In this short time he has won seven decorations—viz., the Stanhope Gold Medal, the Royal Humane Society's Silver Medal, the Arnott Gold Medal, the Silver Medal of the French Society for Salvage of Shipwrecks, the Distinguished Service Order, and the two medals for the South African war with four clasps.

Since the last report sixteen candidates, having passed the examinations, were admitted to the Fellowship. Sixty-seven candidates, having passed the Conjoint Examination with the Royal College of Physicians, received the Diploma in Surgery and Midwifery. Thirteen candidates, having passed the Conjoint Examination with the Royal College of Physicians, received the Conjoint Diploma in Public Health. Nine candidates, having passed the examinations, received the Licence in Dental Surgery. Sixty candidates, having passed the Conjoint Preliminary Examination with the Royal College of Physicians, received certificates. Eight Fellows, forty-two Licentiates, and eight Licentiates in Dental Surgery died during the year. There are at present living 11 Honorary Fellows, 443 Ordinary Fellows, 2,857 Licentiates, 6 Honorary Diplomates in Public Health, 193 Ordinary Diplomates in Public Health, and 516 Licentiates in Dental Surgery.

At a meeting of the Fellows held on Monday, June 5th, the following were elected:—President—Arthur Chance; Vice-President—Henry R. Swanzy. Hon. Secretary—Sir Charles Cameron; Council—Edward H. Bennett, William Stoker, Sir Charles A. Cameron, John B. Story, Sir William Thomson, Sir Charles B. Ball, Sir Thomas Myles, John Lentaigne, Richard D. Purefoy, Sir Lambert H. Ormsby, Henry G. Sherlock, R. Bolton McCausland, John S. M'Ardle, Robert H. Woods, Thomas Donnelly, William Taylor, Edward H. Taylor, G. Jameson Johnston, and R. Charles B. Maunsell.

Trinity College, Dublin.

THE following candidates passed the final examination in midwifery during Trinity Term, 1905:—Henry A. Emerson, Cecil A. Boyd, Charles R. Morris, Howard English, William F. Samuels, John Murdock, William G. Harnett, and Charles C. Williams (equal). Thomas T. H. Robinson, Wilfred L. Myles, Henry H. White, William C. MacFetridge, Francis J. Usher, John Chambre. M.A.O. Degree:—Paul Carton, M.D., Samuel Synge (clk.), M.D.

Notices to Correspondents, Short Letters, &c.

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

SPRING FEVER.

Same old thing
Comes every Spring.
It's late this year,
But it's here
Just the same,
Same weary frame,
Brain fog,
Legs that lag.
Don't have to go
To a doctor in order to know
What has gone astray
When a fellow feels this way.
It's the spring fever sure,
And the only cure
Is to loaf to-day,
And the coming day,
And every other day,
Till it goes away.—*Bulletin of Pharmacy.*

DR. F. (Cornwall).—We believe that at the Institute you mention the chief nostrum used for the cure of diabetes is a preparation of jambul, which drug has been used with uncertain results for many years in diabetes. How any educated person can go to quacks for the cure of this complicated and distressing disease is simply amazing.

ANTIQUA (Dunblane).—We are obliged by your offer of Curious Remedies, but we receive and have not space to make use of many of a similar nature. The subject is a hackneyed one.

COLONIAL.—Dr. Smith, Superintendent of the Leper Hospital at Tracadie, New Brunswick, says that beneficial results have been gained by the use of chaulmoogra oil. Extensive experiments, however, do not appear to have established the reputation of that drug as a medicinal agent of any great value.

CYCLING AND EPILEPSY.

EPILEPSY writes: "I have a patient, a youth, aged 20, who has occasional epileptic attacks, and who is bent upon learning to ride a bicycle. His parents have referred the matter to me, and I am doubtful what answer to give them. I would be glad to know if any of your readers have had experience of a similar case."

CAPTAIN J. S.—Nothing bearing upon the decision of the War Office has so far been brought under our notice.

EPSOM COLLEGE PENSIONERS & FOUNDATION SCHOLARS.

NOTICE will be found in our advertisement columns of the coming election of Pensioners and Foundation Scholars, the election and re-election at the Annual General Meeting of Members of Council, and the alteration of certain bye-laws governing this medical charity. The meeting will be an important one and voting papers must be returned to the Secretary by the 18th inst. at latest, or they will be lost.

G. T. L.—The Medical Officer of Health was legally correct, but his remarks were decidedly wanting in tact.

A CORONER'S DEFINITION OF A QUACK.

In the resumed enquiry, at Stoke Newington, concerning the deaths of two children, alleged to have been caused by the taking of an American quack preparation called "Liquozone," Dr. Wynn Westcott, the coroner, said his view was that "a qualified medical man prides himself on not dispensing any medicine of which he does not know the constituents. The quack, on the other hand, puts medicine of which he knows little into bottles of which he knows less."

STATISTICIAN.—The birth-rate is lower among savages because the period of lactation often lasts two years, and large families are not regarded with favour.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JUNE 7th.

OBSTETRICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Mr. H. Paterson, Dr. Singe (introduced by Dr. Handfield-Jones), Dr. R. Andrews, Dr. Lewis, Dr. Boxall, Dr. Falstaff, Mr. Targett, and Dr. Cullingworth. Short Communications.—Mr. A. Doran: Repeated Tubal Pregnancy.—Dr. H. Bell: On the appearance of Thyroid-like Structures in Ovarian Cysts. Paper.—Surgeon-Captain J. C. H. Leicester: A Case of Ecolapsia, with Death on the Sixteenth Day after Delivery from General Septic Peritonitis due to Rupture of an Abscess in the Spleen.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. G. L. Cheatle: Clinique. (Surgical.) 5.15 p.m. Dr. G. A. Sutherland: Pneumonia in Children.

THURSDAY, JUNE 8th.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—8 p.m. Card Specimens will be shown by Mr. G. Coats, Mr. G. W. Thompson, Mr. L. Werner, Mr. J. H. Parsons, Mr. G. S. Keeling, and Mr. J. H. Fisher. 8.30 p.m. Papers: Mr. R. W. Doyne and Mr. S. Stephenson: A Note upon Crithiform Choroido-Retinitis, a rare form of Fundus Disease.—Dr. G. A. Berry: (1) On Trellis like Keratitis; (2) On the Question of Visual Efficiency.

—Mr. L. Paton: The Subsidence of Optic Neuritis after Removal of Cerebral Tumours. Mr. L. Werner: Ring Sarcoma of the Uveal Tract originating close to the Angle of the Anterior Chamber, Intense Melanosis of the Iris and of the Angle of the Anterior Chamber in its Whole Circumference; Secondary Glaucomas.—Mr. F. R. Cross: Further Note on a Case of Orbital Tumour previously shown.—Dr. W. E. Cant: The Use of Strong Applications in the Treatment of Ophthalmia.

BRITISH GYNECOLOGICAL SOCIETY (20 Hanover Square, W.).—9 p.m. Address: Dr. H. Kelly (Baltimore): Tuberculozoids of the Urinary Tract in Females. Followed by a Conversation.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Mr. E. Clarke: Lachrymal Obstruction, its Causes and Treatment.

FRIDAY, JUNE 8th.

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

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Lecture-Demonstration:—Dr. R. M. Leslie: Prognosis in Heart Disease.

TUESDAY, JUNE 13th.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Dr. R. M. Leslie: Prognosis in Abdominal Affectious.

Vacancies.

Manchester Royal Infirmary and Dispensary.—Honorary Assistant Physician. Applications to the Secretary. (See Advt.)

Richmond Hospital, Dublin.—Anaesthetist. Immediate Applications to Secretary of the Board of Governors. (See Advt.)

Dowd District Lunatic Asylum.—Junior Male Assistant Medical Officer. Salary £100 per annum, with furnished apartments, board, &c. Applications to the Resident Medical Superintendent not later than June 12th (See Advt.)

Royal Free Hospital, Gray's Inn Road, W.C.—Senior Resident Medical Officer. Salary £100 per annum, with board, residence, and washing. Applications to the Secretary.

Salford Royal Hospital.—Senior House Surgeon. Salary £110 per annum, with board and residence. Applications to George Eadie, Secretary and Superintendent.

Salford Royal Hospital.—House Physician. Salary £100 per annum, with board and residence. Applications to George Eadie, Secretary and Superintendent.

Salford Royal Hospital.—Junior House Surgeon. Salary £90 per annum, with board and residence. Applications to George Eadie, Secretary and Superintendent.

Nottinghamshire Consumptive Sanatorium, Mansfield.—Resident Medical Officer. Salary £100 per annum. Applications to the Clerk, Mr. G. Sheldon, 38A, Bridlesmith Gate, Nottingham.

Appointments.

BEATTIE, D. A., M.D. Toronto, Clinical Assistant to the Chelsea Hospital for Women.

CREASER, THOMAS, B.A., M.B., Ch.B. Dub., Junior House Surgeon to the Bootle Borough Hospital.

DODD, JOHN, M.D., M.Ch., R.U.I., Visiting Medical Officer to the Leicester Poor-law Infirmary.

HODGSON, STANLEY, M.D., B.S. Lond., M.R.C.S. Eng., Honorary Physician to the Pendleton Branch Dispensary of the Royal Salford Hospital.

RUTHERFORD, J. W., House Surgeon to the Richmond, Whitworth, and Hardwicke Hospitals.

LEBOE, J. W., House Physician to the Richmond, Whitworth, and Hardwicke Hospitals.

TORIN, R. F., F.R.C.S.I., Consulting Surgeon to the City Hospital for Disease of the Skin, Dublin.

Births.

GOODCHILD.—On May 30th, at Highgate Road, London, the wife of N. John Goodchild, M.R.C.S., of a son.

MARSHALL.—On June 3rd, at West House, Southminster Essex, the wife of Thomas Bingham Marshall, M.R.C.S., L.R.C.P., of a son.

Marriages.

CHILD—HANCOCK.—On June 1st, at the Parish Church, Knareborough, Francis Joseph Child, M.A., M.B., second son of John Child, 10 Holland Villas Road, Kensington, to Lucy, second daughter of the Rev. Canon W. E. Hancock, M.A., vicar of Knareborough.

Deaths.

SUTCLIFF.—On May 27th, at Chagford, Edward Harvey Sutcliff, M.B. of Torrington, Devon, aged 32.

HUNTER.—On June 3rd, at Brookfield House, Gosport, Blanche Georgina Fanny, the beloved wife of Edwin John Hunter, L.R.C.P., and second daughter of the late Major-General A. H. L. Wyatt, formerly of the 11th Devonshire Regiment.

JAMESON.—On June 1st, at Klerksdorp, Transvaal, Thomas Ross, second son of the late Thos. Jameson, M.D.R.N., and of Mrs. Jameson, Allison Gardens, Dulwich, aged 31.

PARSONS.—On June 2nd, at 6 Hillside, Cotham, James St. John Gage Parsons, F.R.C.S., in his 87th year.

FOR SALE.—MEDICAL PRACTICE near Manchester: Death Vacancy. Receipts for 1902, 1903, 1904, £250, £340 and £480. Rent £28. Very low premium will be accepted. Especially suitable for a young practitioner.—Address, Vernon 8, Wood, Solicitor, 40 Deansgate Arcade, Manchester.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX"

VOL. CXXX.

WEDNESDAY, JUNE 14, 1905.

No. 24.

Original Communications.

A PROPOSAL TO CHANGE THE TITLE OF LICENTIATE TO THAT OF MEMBER OF THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH. (a)

By DAVID WALSH, M.D. EDIN.

Senior Physician, Western Skin Hospital, London, W.; Honorary Secretary of the Association of Medical Diplomates of Scotland, &c.

THE approach of the Quatercentenary of the Royal College of Surgeons of Edinburgh reminds us that its Licentiates and Fellows still labour under various disabilities in many parts of the United Kingdom. For instance, by an unjust condition enforced in all the great London, and in not a few of the provincial, hospitals Fellows of the Scotch and Irish Colleges are not eligible to appointments on the honorary medical and surgical staffs. The public generally cannot possibly realise the injustice which they, as governors and electors of the medical charities, are thus led into perpetrating. The result has been to hand over to two English colleges practically a monopoly of the most important hospital appointments in London, to say nothing of England and Wales. It is to be hoped that the Scotch Colleges will give their hearty support to the removal of the indignity thus inflicted upon their Licentiates and Fellows. The matter has been taken up energetically by the Association of Scotch Diplomates, and it is proposed to unite with the Irish Diplomates in a determined effort to put the matter before the public in its true colours.

There are other matters in which it is desirable that the Scotch Colleges should co-operate with our Association. One of the chief, perhaps, is a modification of the title of Licentiate bestowed by the College of Surgeons of Edinburgh and by the Faculty of Physicians and Surgeons of Glasgow.

The ordinary qualification of the English College is that of Member. The Licentiateship of a college is regarded as of less value than that of Membership. Is there any reason why the Scotch Diplomat should not in future become a Member instead of a Licentiate, and thereby be placed on a footing of titular equality with Members of the English College? That the difference between the Licentiate and the Member is nominal is shown by the hybrid qualification of the Conjoint English Board, namely, Membership of the Royal College of Surgeons and Licentiateship of the Royal College of Physicians of England. As the L.R.C.P.

of Edinburgh is already on titular equality with that of L.R.C.P. England, and a Membership exists in both Colleges of Physicians, there is no particular need to raise the question so far as the L.R.C.P. of Edinburgh is concerned. The Edinburgh College of Surgeons, on the other hand, does not possess the Membership which it is now asked in future to confer instead of the Licentiateship.

There can be little doubt that in the eyes of the public a Licentiateship is of less standing than a Membership. Certainly it occupies the position of inferior value among the medical profession. In one instance a pert house-surgeon, full of the pride begotten of a freshly gained diploma of the English College Membership, spoke of the senior surgeon of the hospital, a man of ripe years and experience, from whom he had differed, as a "mere Licentiate." Bad taste of that kind we may hope and believe to be rare in the medical profession, but it shows how the titular difference may be used by unscrupulous persons to sway outside opinion. Lastly, the difference between M.R.C.S. and L.R.C.S. undoubtedly gives an unfair advantage in the competition for many public appointments, and may become the subject of sarcastic comment in various courts of law.

The London Society of Apothecaries has a Membership as well as a Licentiateship.

The English Physicians confer a Licentiateship, a Membership, and a Fellowship (the last-mentioned being purely honorary and bestowed without examination).

The Irish College of Physicians gives a Licentiateship, Membership, and Fellowship. The Fellowship is by ballot.

The Irish College of Surgeons have Licentiates, Members, and Fellows, all by examination.

The English College of Surgeons grants Membership and Fellowship both by examination.

The Edinburgh College of Surgeons grants Licentiateship and Fellowship, both by examination.

Our first great contention is that the Royal College of Surgeons of Edinburgh should grant a Membership instead of an ordinary Licentiateship. That alteration can probably be brought about without any change in the charter. If such change be found necessary, then the Council of the College will probably be enabled to obtain the requisite additional powers by a properly presented petition to his Majesty King Edward VII. It is quite likely, however, that the required authority will be found within the lines of the existing charter.

As an alternative plan, it would be reasonable

(a) Read at the General Meeting of the Association of Medical Diplomates of Scotland, May 24th, 1905.

for the Royal College of Surgeons to make the Licentiate the first step as heretofore, and to permit Licentiates at the end of a given period, say twelve months, to proceed to the Membership upon payment of a moderate fee, which certainly should not exceed five guineas in addition to the fees payable for the Licentiate, which are already ample. So far as existing Licentiates are concerned, it should be possible for them to assume the newly-created Membership on payment of a small registration fee, say one, or at the most two, guineas. In this way the wishes of the Licentiates would be adequately met, the College would gain a legitimate addition to its revenues, and, last but not least, the bond of union between the Diplomates and their *alma mater* would thereby be strengthened and perpetuated.

Much the same line of reasoning applies to the Licentiate of the Faculty of Physicians and Surgeons of Glasgow. The present title, with the letters, L.F.P.S.G., is cumbrous, and to the average British citizen quite meaningless. Some compromise might be found conferring the Membership and omitting the word "Faculty." M.R.C.S.&P.Glasg. would be a generally recognisable and desirable title.

Perhaps a better plan would be to combine the cumbrous titles conferred under the present conjoint diploma of the Edinburgh College and the Glasgow Faculty into one combined Scotch Membership. The Royal College of Surgeons of Scotland was in existence four hundred years ago. Would it not be possible to have a real conjoint diploma of *Scotland*, of which there would be Licentiates, Members, and Fellows? The title of a Diplomate would then be Licentiate, or Member or Fellow, as the case might be, of the Royal College of Surgeons, Scotland. How much more dignified, for instance, would be the letters M.R.C.S., L.R.C.P.Scotland, than the cumbrous L.R.C.S.&P.Ed., L.F.P.S.Glasg.! The English Diplomate is M.R.C.S.England. The Irish Diplomate L.R.C.S.Ireland. Why should not the Scotch Diplomate be L.R.C.S. or M.R.C.S.Scotland?

Whether the creation of the Diploma of Membership would confer any privileges upon a member of the Edinburgh or Glasgow Royal Colleges, is very much a matter for the Councils of these bodies to decide. It would be more in accordance with the liberal traditions and policy of the Scotch Colleges to grant an adequate representation and weight to Diplomates in the government of their own College. There is, of course, the alternative policy of the English College, which denies to Members any voice whatever in College matters.

Now, as to practical steps to bring these proposals before the Royal College of Surgeons of Edinburgh and before the Faculty of Physicians and Surgeons of Glasgow, there are two plans:

1. A formal petition from the Association of Scotch Diplomates, setting forth the facts of the case, and making a request for inquiry and for all practicable concessions.

2. A general petition from Diplomates of the Scotch qualifying corporations concerned asking for the proposed modifications of title from Licentiate to Membership.

The Association appeal can be readily accomplished in the course of the ordinary business of the Society.

The general petition, however, demands a good deal of work and an expenditure of money which can hardly be undertaken by the Association in

its present youthful stage. A country Member has written offering to contribute to a special fund for that purpose, and a subscription list might be opened for the specific end of defraying the costs of the petition. As a matter of fact the movement is already on foot, and the present writer, as Honorary Secretary of the Association of Medical Diplomates of Scotland, has already received several subscriptions.

This important matter simply wants to be taken up with sufficient energy and enthusiasm to be sooner or later conducted to a successful issue.

CARCINOMA :

ITS DEFINITION, BIOLOGICAL AND OTHERWISE.

By K. W. MONSERRAT, M.D., F.R.C.S.EDIN.,
Surgeon, Northern Hospital, Liverpool, &c.

THE word "carcinoma" appears to have been first applied in human pathology by Hippocrates, who used it in a descriptive sense for what is now spoken of as carcinoma of the breast. In common with most of the ancients in medicine, he chose his nomenclature on the basis of fanciful resemblances between the appearances presented by different types of diseased and normal structures and certain objects of common knowledge.

Malignant disease of the breast, with its radiating dilated veins, its densely hard processes, and its grip of the chest wall, seemed to him like nothing so much as the crab with its tenacious claws.

In later times attention was drawn to the eating away of the tissues which was characteristically seen in the condition, and from this fact the term came to be given a wide significance and was applied to ulcerative processes in general.

Cruveilhier (1) was one of the first to approach, in his use of the word, its modern significance. He applied it to all forms of incurable tumour which became generalised throughout the body.

In the early decades of the nineteenth century, there was much discussion as to whether such tumours were parasitic. It was suggested that they attached themselves as parasitic growths to the tissues and became implanted thereon.

To this view Cruveilhier does not appear to have assented, and it gradually disappeared as the researches of Schwann (2) and Lebert (3) showed that the real origin of the tumours was from the body tissues themselves.

These researches led the way to the all-important work of Virchow. In adopting the term "carcinoma," Virchow (4) gave to it a *histo-morphological* significance. Dividing the true tumours into "histoid" and "organoid," the former composed of tissue elements of one kind, the latter of tissue elements of more than one kind, he applied the word "carcinoma" to the malignant organoid tumours.

There followed the researches of Thiersch (5), Waldeyer (6), and Hauser (7), in which it was shown that Virchow's "organoid" tumours arose, not from connective tissue by metaplasia, but from pre-existing surface lining or glandular epithelium. Thereupon, the term "carcinoma" came to have attached to it a new, a *histo-genetic*, significance, and was defined in this sense as a malignant tumour of epithelial origin.

Coincident with the evolution of this new distinction, the researches of embryologists appeared to show that all epithelium had origin from the

epiblastic and hypoblastic layers of the embryo. Pathologists were not slow to welcome these statements as affording an opportunity for an embryological classification of tumours. In this classification, carcinomata found a place, and the term acquired a third definition as a malignant tumour arising from structures of epiblastic or hypoblastic origin.

In this manner the word "carcinoma" came to be endowed with a three-fold significance,—histo-morphological, histo-genetic, and embryogenic.

It is not necessary here to follow the whole course of the discussion on tumour classification, nor to consider the embryological researches of His (8), and their adoption by Klebs (9), and Williams as a basis for this classification. The question which concerns us, whether carcinoma is capable of this threefold definition in the light of modern work?

In the first place, with regard to its definition as a tumour originating from epiblastic or hypoblastic structures: Many facts which have lately been brought to light by embryological and pathological research, show the impossibility of retaining this definition in its original sense. On the one hand, it has been shown that certain organs and tissues, from which arise tumours exactly resembling in morphology the carcinomata of epiblastic structures, have origin from the mesoblast and not from the epiblastic or hypoblastic layers. From the kidney, the ovary, the testis and the uterine mucosa arise tumours which are not to be distinguished in their general morphological characters from carcinomata of the digestive tract, the breast, and so on, although the kidney, ovary, testis and uterine mucosa are mesoblastic in origin.

On the other hand, it has been shown that from epiblastic structures new growths arise which in their morphology answer not to what histologists call carcinoma, but to the sarcoma type, for example, the *glio-sarcomata*.

From these observations has arisen the necessity of choosing between two alternatives, either to dissociate from the term any implied relationship to one or other of the primitive embryonic layers, or to restrict or abandon its morphological significance.

A few pathologists have chosen the latter course, and, refusing to speak of carcinoma of the kidney and uterine mucosa, and objecting to the term "*glio-sarcoma*," would apply and restrict the term to all malignant growths of the epiblastic and hypoblastic structures. The exclusion of any histo-morphological significance has, however, several disadvantages. From its invention it has been used primarily in this sense, and all other definitions have been added thereto; if it were agreed to confine it to epiblastic malignant tumours, there would be excluded from the class a considerable number of the malignant "*organoid*" growths and for these some new descriptive term would have to be invented.

The consensus of opinion is greatly in favour of retaining its morphological significance, so that many writers have followed Thoma (10), Ribbert (11), and Hamilton, in refusing to include in the definition of carcinoma any reference to the three embryonic layers. The confusion which follows such inclusion is illustrated by the classification approved by Senn (12), in his "*table*" carcinoma is

described as an epiblastic or hypoblastic tumour, while in the text he speaks of carcinoma of the kidney, mucosa, and so on, without comment. If, then, a definition cannot be constructed in both morphological and embryo-genic terms it remains to be asked whether a histo-genetic meaning, as well as a morphological, can be attached to it; in other words, may carcinomata be defined as malignant growths of epithelial origin?

Following the researches of Thiersch and Waldeyer, came those of Wagner (13), Boström (14), and others, showing that growths, morphologically resembling the carcinomata of epithelium, arose from serous and lymphatic endothelium. In spite of this, the statement that carcinomata were epithelial tumours was retained in most textbooks. When later the question arose as to whether the word "*endothelial*" should be added to this statement, it was objected that many of the endothelial new growths were distinctly of the connective-tissue type, so that to say that carcinoma is of endothelial origin is not true to the same extent as to say that it is of epithelial origin.

Two views of the histo-genetic definition have been taken of late years. The chief exponent of the one is Hansemann (15), who denies that any such definition can be accurate in that it is not possible to define epithelium histologically or developmentally. According to his view, epithelium can only be defined as a tissue consisting of cells in close order, lining surfaces and distinguished by their bipolarity and with this definition the endothelia fall in; he maintains again that a tumour can only be called epithelial when its parenchyma cells are arranged in the epithelial manner and that this arrangement is to be found equally in tumours derived from epithelium and from the connective tissues.

In his recent work, Borst (16) expresses a contrary view. Admitting, he says, that histologically and developmentally epithelium cannot be defined, yet it is possible to distinguish the epithelia from the connective tissues on the ground of biological characters.

He would define epithelia biologically as the cell structures which line the surfaces and glandular tissues of the body; and he separates off the endothelium of the blood and lymph channels (except the serosa) from the epithelial class and places it with the connective tissues.

Having thus defined epithelium, he proceeds to describe carcinoma as a malignant tumour of epithelial origin.

There are several objections to this so-called biological definition of epithelium. In the first place, the endothelium of the blood and lymph channels is not to be distinguished histologically from the endothelium of the serosa, in the second place from the serosa (*e.g.*, the peritoneum) arise tumours of distinctly sarcomatous characters; in the third place it is by no means certain that all the endotheliomata of the peritoneum which show an alveolar structure with stroma and parenchyma are derived from the surface endothelium, and not from that lining the lymph channels and spaces of the membranes.

For these reasons, Borst's attempt to retain for carcinoma a histo-genetic significance must be considered to fail, and we are compelled to agree with Hansemann's arguments against it.

Having decided to retain the histo-morphological significance, and having found that neither

an embryonic nor a histo-genetic definition is compatible with this, it remains to define carcinoma in its histo-morphological sense.

It is not sufficient to state, with Hansemann, that carcinoma is a malignant tumour consisting of a distinct parenchyma and stroma, for there are elements in the sarcomata to which these terms may be legitimately applied. Recent researches have shown, however, that the arrangement of parenchyma and stroma in the sarcomata differs from that in the recognised carcinomata; in the former the stroma is intercellular, in the latter it is not intercellular but separates the parenchyma cells into groups. The definition here proposed is, therefore, as follows:—Carcinomata are malignant tumours consisting of a definite parenchyma and stroma in which the stroma is found between groups of parenchyma cells, but not between the individual cells themselves. It must be admitted that this definition is clumsy, but it accurately defines the histo-morphological characteristics of carcinoma, and permits of an exact distinction between the carcinomata and the sarcomata.

The conception concerned is, of course, an old one which has been but more firmly based by recent researches on the stroma of malignant growths. It is not the purpose of this note to attempt the introduction of any new facts into the controversy on the definition of carcinoma, but to demonstrate how impossible it is to define the term in any other than a histo-morphological sense without the introduction of a confusion that cannot be successfully handled.

If the term be divested of all histo-genetic significance, there is no difficulty in classifying the tumours arising from endothelium; some are carcinomata, some sarcomata. The term endothelioma should be discarded and its place taken by carcinoma and sarcoma, as the case may be, according to the histological type of the particular growth concerned. In the case of all growths, whenever the tissue of origin—that is to say, the histo-genesis—can be traced, this should be added to their description; thus, carcinoma of the vascular endothelium of the breast, sarcoma of the connective tissue of the biceps, and so on; but to "carcinoma" and "sarcoma," no histo-genetic or embryo-genic significance should be attached.

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- (14) Das endothelcarc. Erlangen. 1881.
- (15) "Die Mikr. Diagn. der Bösart. geschwulste," 1902.
- (16) "Die Lehr. v. d. geschülsten." Bd. II., p.163.

It is announced that nearly £7,000 has been promised for a sanatorium for consumptives for Dumfriesshire.

THE employes of a number of workshops, &c., have contributed £5,390 6s. 7d. to the London Hospital Saturday Fund.

THE RECENT OUTBREAK OF SMALL-POX IN THE CITY OF BELFAST. (a)

By A. GARDNER ROBB, M.D., D.B.H.

Visiting Physician to the Fever Hospital, Medical Superintendent to City Small-pox Hospital, Belfast.

THE recent outbreak of small-pox in the city terminated with the discharge of the last case from the hospital at Purdysburn on April 29th. The hospital had been in constant occupation for eighteen months, the first case being admitted on October 28th, 1903. In all, 178 cases were treated in hospital and two other cases were known to have occurred in town, which were not removed to hospital.

The disease was first introduced from Glasgow by an employé in one of the shipyards. This case was admitted to the Union Infirmary on the seventh day of his illness and from there transferred to Purdysburn. He gave rise to several other cases among his friends. Small-pox is most energetically dealt with in Belfast. Very thorough measures are taken to prevent the spread of the disease. The patients are removed immediately to the special hospital; clothing, &c.; in immediate contact with the patient being burned, all persons known to have been in contact are, so far as possible, removed to the "Contacts' Reception Hospital" at the Twin Islands, re-vaccinated, and detained in quarantine, their houses thoroughly disinfected, and re-vaccination offered and urged to all persons employed in the same works with these contacts. In this way, and by the readiness with which re-vaccination has been generally accepted here, small-pox, although frequently introduced, has for many years past made little headway in Belfast, this recent outbreak being much more extensive than any occurring in the last twenty years. The failure to completely stamp out the disease immediately in this instance is accounted for in two ways—first, that for some reason difficult to understand, re-vaccination was not at first so generally resorted to as in former outbreaks, and secondly, that the outbreak was not due to a single introduction, but to several. In some cases it was not found possible to trace the exact source of infection, but it is known to have been introduced on 9 separate occasions, spread over the 18 months:—

1. (In the case mentioned.) On October 28th, 1903, from Glasgow.
2. Again on November 29th, 1903 from Newcastle-upon-Tyne.
3. Again on December 2nd, 1903, from Glasgow.
4. On March 10th; again from Glasgow.
5. On June 4th, from Ayr. This case arrived at Newry from Ayr in incipient stage of a mild attack, and tramped by Banbridge to Lisburn, where he stayed three nights, and then tramped to the Belfast Union, where he was diagnosed on applying for admission and removed to Purdysburn. He gave rise to several cases in Lisburn owing to the owners of the lodging-house in which he stayed denying that he had been there, and refusing re-vaccination; in Banbridge, where he had stayed one night, the lodging-house keeper and family were removed to the local fever hospital, re-vaccinated and kept in quarantine, and Banbridge-escaped.
6. On June 15th, 1904; again from Ayr.
7. On June 24th, from Liverpool.
8. On July 28th, from contact with the first of the Armagh cases.
9. On September 30th, from contact with three Clones cases.

In the majority of these cases of fresh introduction other cases followed, although in some the patient was removed without having time to cause any spread of the infection.

In any outbreak of small-pox and in an examination of the figures given by it, perhaps the point of most

(a) A Paper read before the Ulster Medical Society.

general interest is the evidence given by these figures of the value of vaccination. The evidence given by an analysis of the 178 cases we have just had in this respect is overwhelmingly in favour of thorough vaccination, and of re-vaccination.

I give below the percentage mortality in age periods of the vaccinated and unvaccinated cases:—

Age	WITH VACCINATION MARKS.			WITHOUT VACCINATION MARKS.		
	Cases.	Deaths.	%	Cases.	Deaths.	%
Under 5 years	4	0	0'00	6	1	16'66
5 to 10	7	0	0'00	8	1	12'50
10 to 20	25	0	0'00	5	0	0'00
20 to 30	46	1	2'17	5	1	20'00
30 to 40	41	0	0'00	4	2	50'00
Over 40	23	1	4'34	4	2	50'00
Totals	146	2	1'36	32	7	21'87
			Cases.			Deaths.
Vaccinated	146	2	1'36			
Unvaccinated	32	7	21'87			
Total	178	9	5'05			

*In these four cases vaccination had only been performed after infection.

Eight cases were vaccinated only after infection. In those in which the onset of small-pox took place within six days of such vaccination the cases have been included in the unvaccinated numbers, and where the term exceeded six days the cases have been included in the vaccinated numbers.

It will be seen from this table that while the death-rate in the unvaccinated cases was 21'87 per cent. (a low rate when compared with other epidemics), the mortality in the vaccinated was only 1'36 per cent.

Of the two cases showing vaccination marks, which proved fatal, one was a man, æt. 40, who at the time of contracting the disease was only recovering from the effects of an accident in which he had lost portions of several fingers through being caught in machinery, and in which there had been prolonged suppuration. In this case there were two vaccination marks both very indistinct, and only $\frac{1}{4}$ sq. inch in total area. The other was a man, æt. 25, who showed only one indistinct vaccination mark, and who had been much addicted to over-indulgence in alcohol, had previously suffered from kidney trouble and who died with suppression of urine and repeated convulsions twenty hours after admission to hospital, and on the fourth day of the disease. I think it probable that any severe febrile disease would have had the same result with this patient.

In the four vaccinated children under five years who were attacked and who recovered, in all of them vaccination had only been performed after the disease had been contracted.

On the subject of the value of vaccination it might be thought that to a society such as ours, and at this time of day, it was quite unnecessary to emphasise the facts. While that is true, and while it is a fact that I have never yet met a medical practitioner who did not claim faith in vaccination as part of his creed, I believe that that faith is not always so absolute as it should be, and as it would be, had we all opportunities of observing closely the effects of vaccination of various degrees of thoroughness afforded by the treatment of any considerable number of cases of small-pox in a limited time. The evidence given by such figures as the mortality table I give of our recent cases is strong, but to my mind it is not so striking as the evidence given by watching the behaviour of the larger number of cases in which recovery takes place and in which it is found that the severity of the course of the attack depends directly on the character of the vaccination scars. For example, it is frequently found that cases arriving in hospital on the fourth or fifth day with very severe symptoms run very different subsequent courses according to the character of the primary vaccination scars; and even in cases with very severe initial symptoms and copious eruption, the prognosis may be allowed to almost entirely depend on the

nature of these marks. Without a careful examination of the vaccination scars a prognosis in small-pox should never be given, as it is almost certain to be incorrect. While cases with severe early symptoms and good vaccination marks invariably run a short course, and are generally able to be up and about in ten days or so after admission to hospital, similar cases with indifferent marks will continue suppurating with considerable elevation of temperature into the third week with slow and tedious convalescence.



FIG. I.—Photograph of three members of the same family showing the effect of vaccination. A, unvaccinated, sixth day of disease; B vaccinated, ninth day; C, unvaccinated, eighth day.

If the marked and constant difference in course run by well vaccinated and indifferently vaccinated cases were appreciated, I am satisfied that the cases we meet with showing evidence of perfunctory vaccination would rapidly become much less numerous.

I regret to say that in three children who developed severe attacks and who showed no marks of vaccination, and where close inquiry showed that no result had followed the operation for vaccination, it was found that certificates of successful vaccination had been signed and had been so registered.

The evidence of the protective value of re-vaccination in our Belfast experience has been very strong. Not one of the 178 cases had been successfully re-vaccinated. I have never seen small-pox in a re-vaccinated subject. It will be freely admitted that small-pox is about the most infectious of diseases, yet it is found that it is the only infectious disease in which doctors, nurses, and attendants are safe from attack. During the eighteen months of the recent outbreak the officials of the Purdysburn Hospital, who were brought closely in contact with the cases, numbered twenty-eight; all had been re-vaccinated and none contracted the disease. In my experience of six outbreaks no doctor, nurse, nor attendant in hospital has ever been attacked, re-vaccination before going on duty with the small-pox cases being with us compulsory.

Some years ago the Epidemiological Society of London collected statistics of 1,500 officials closely connected with small-pox hospitals. Among these it was found that 43 had contracted the disease. Not one of these 43 had been re-vaccinated with success. The results among the public health staff in Belfast have been similar. During the last fifteen years three cases of small-pox have occurred in individuals more or less connected with the health department whose duty brought them into contact with the cases. The first of these was a sanitary inspector who developed a severe attack in 1892—at the beginning of the outbreak in that year all the inspectors, &c., were re-vaccinated,

some time later this inspector, who was attacked, had been transferred from the house-cleansing department. He slipped in without re-vaccination, and kept quiet about it, hoping to escape the "sore arm" with the result that he only was attacked, and he still bears marked evidence of his folly on his face. During the recent outbreak the wife of the sanitary inspector who lives at the Twin Island Hospital refused re-vaccination and in due course developed small-pox. The third case was a man who for years had done limewashing of houses and yards after removal of small-pox cases. He was not under the control of the health department, but stated that he had been vaccinated and re-vaccinated. This statement was untrue, as he had never been vaccinated at all. His duty as a rule, only brought him to houses from which cases had been removed after the sanitary staff had finished disinfection, but through a mistake he turned up at a house in Manor Street a day too soon. When there he helped with the burning and removal of infected clothing, and eleven days later was attacked with what developed into a severe confluent attack, and he died on the fifteenth day of the disease. These are the only cases occurring in fifteen years, they were the only officials not protected by vaccination and re-vaccination, all three went under and one died. My experience in the Fever Hospital has been that every year some of the doctors, nurses, or attendants go under with every other form of infectious disease from German measles to typhus, but from small-pox we have complete immunity.

On the diagnosis of small-pox I am afraid our recent experience has added nothing that is new, but it has served to emphasise to us the points on which reliance may be placed. Through the arrangement made by the Health Authorities by which I was sent to see a large number of cases in which suspicious symptoms were found, I had an opportunity of seeing a very valuable number of very early cases and of doubtful cases. Formerly I had only the opportunity of seeing doubtful cases which were sent into hospital for observation, there they could be placed in isolation and a diagnosis made with dignified leisure. The arrangement in the recent outbreak where the diagnosis was required at sight in the patients' home was calculated to considerably stimulate one's interest in points of differential diagnosis.

Among the cases in which suspicious symptoms occurred, and which did not prove to be small-pox, measles and German measles, especially in adults, occurred most frequently. Urticaria, eczema, scabies, and syphilitic cases were numerous, and many were chicken-pox.

To whom belongs the credit of having first pointed out the great value of the different distribution of the rashes in chicken-pox and small-pox I do not know, in no work on small-pox I know of is sufficient stress laid on this point. I believe that this point is so reliable that where the rash in either disease is at all well marked, confusion is not likely to occur if the disease is seen in the acute stage. In small-pox cases, where the rash is at all abundant, it is always found well-marked on the face, and plentiful on the arms below the elbow, and all over the hands, with comparatively little over the trunk especially the abdomen and sides of the chest (photos shown), while in chicken-pox the rash is comparatively abundant on the trunk, while the arms below the elbow and the hands almost entirely escape, and it is rare to find more than a few very poorly developed vesicles in this site.

Taken as a whole the severity of the 178 cases in this latest outbreak was about the average of recent outbreaks here.

The smallness of the number of cases in which complications occurred confirms the opinion that small-pox received into hospital early and well nursed is less liable to be followed by severe complications than any other form of serious infectious disease. The eyes, which, according to older writers were frequently seriously affected, under the early use of mild antiseptic lotions give little trouble. Marked œdema of the lids,

causing complete inability to see for from one to three days, was the rule in the severe confluent cases, but quickly subsided. More tedious conjunctivitis occurred in a few cases. In one only was there more serious trouble—namely, iritis with abscess of the cornea and prolapse, giving rise to permanent impairment of vision, but this was in a comparatively mild small-pox and the patient had a specific history which I believe accounted for most of the trouble.

Abscesses of the skin and scalp, were fairly numerous in early convalescence—the thighs and legs along the tibiae being the most frequent seats; in one case very severe abscess. Alopecia, in some absolutely complete, was the rule in the severer cases, but in all these the hair was growing well again before discharge from hospital. The onset of menstruation independent of the time in the period was practically constant in suitable cases—generally coming on with the appearance of the symptom. Five cases were pregnant. In none of these did premature labour or abortion take place. Two patients were delivered of living children at term during their convalescence. Neither child showed any traces of eruption. Three of these pregnant cases were mild, and two moderately severe.

Hypostatic congestion of the lungs occurred in a few of the cases, which recovered—pneumonia in only one. Maniacal delirium also in a few, generally alcoholics. The treatment of the cases varied very little.

The faces were protected by masks of lint saturated in boric lotion and glycerine—iced when there was much pain, which was generally only for a day or two. This was covered later with G.P. tissue and kept on until crusts were well formed, when the mask was removed, and 1-20 carbolic oil constantly applied. Later antiphlogistine was found a most useful application. Frequent bathing is the most important part of treatment, especially in children. Internally reliance was placed in such antiseptic drugs as the sulpho-carbolates and salol, and in severely septic cases most benefit appeared to follow the administration of quinine and large doses of tincture of iron. Modified "Finsen Light treatment" was adopted in all cases, the windows in the acute wards admitting only red light. Cases are practically never received into hospital in time to obtain the full benefit of the light treatment as claimed by Finsen, but my experience convinces me that even with the modified red light less suppuration occurs, and resolution after suppuration is slower, secondary points of suppuration (generally very troublesome) are less frequent, and that the permanent scarring in confluent cases is less severe. Further than this I am not inclined to rely upon the "light treatment," for, whatever may be the results obtained by strictly following Finsen's suggestions, in actual hospital practice the attempt breaks down, as the cases are not received early enough to fulfil his conditions.

Of the nine fatal cases, one (already referred to) died on the fourth day with suppression of urine and severe convulsions (apparently uræmic). One, a man, æt. 40, died on the seventh day with a hæmorrhagic attack. One, a child of 5, unvaccinated, died on the eighth day of the disease, five hours after admission to hospital. The other six, all unvaccinated—one infant, æt. 16 months, and five adults at ages varying from 29 to 46, death took place from exhaustion, following prolonged secondary fever and a condition of general sepsis at times varying from the twelfth to the sixteenth day of disease.

ON Friday, June 16th, at 4.30 p.m., a discussion will be opened at the Parkes Museum, Margaret Street, London, W., by Mr. Edwin T. Hall, F.R.I.B.A., on Sanatoria for Consumption: Design and Location. Among the speakers will be Mr. H. Percy Adams, F.R.I.B.A., Mr. T. W. Aldwinckle, F.R.I.B.A., Mr. T. W. Cutler, F.R.I.B.A., Dr. C. E. Reinhardt, Mr. A. C. Scovell (chairman of the Metropolitan Asylums Board), Dr. J. E. Squire, Dr. F. R. Walters, and Dr. C. Theodore Williams. Major-General the Right Hon. Lord Cheylesmore will preside.

THE SUCCESSFUL TREATMENT OF FOREIGN BODIES WHICH HAD BEEN SWALLOWED

BY THE INTERNAL ADMINISTRATION OF COTTON WOOL.

By W. BLAIR BELL, M.D.LOND., M.R.C.S. ENG.

I DOUBT whether any of all those accidents which befall children induces in the mother such a state of panic as the swallowing of some foreign body. The fear of the unknowable possesses her; the selected article has gone from light into darkness; and, in spite of the infant's smiling face, there is a vague terror in the heart of that mother.

Those of us who have been hurriedly called in to such cases must have felt that the usual advice to "leave matters alone for a while," or to "give an aperient," does not appeal very strongly to the frantic mother, however satisfactory it may have proved in our past experience. She expects more from science than such nursery tricks as castor-oiling!

I assure those who have never faced the position that it is an uncomfortable one. "Can nothing more be done?" is a question we never get hardened to; and so it was the recognition of the frailty of man well lubricated by a fond mother a short time ago, which led me to adopt the method I bring forward here.

I was sent for to see a child—an only one, to make matters worse—about eighteen months of age. He had gleefully swallowed a gold brooch with the letters B-A-B-Y sticking out on all sides.

By the time I arrived the household could not have been in a greater state of confusion if the child had swallowed a barbed wire fence.

I endeavoured to calm the mother's fears with the usual formula—"it would be all right," or "the child would pass it easily enough." I need not say what I gathered concerning my ability and originality from the glances of the mother and the nurse—my reputation was becoming a speck on the horizon. The mother did not consider she had sufficiently impressed me with the special features of that brooch, but I soon had a horrible mental picture of grappling-hooks and spear-heads. Something clearly had to be done, and it suddenly occurred to me to feed the child on cotton wool.

I did not feel like half measures—you all know the effect a weeping woman who will not listen to reason (or unreason) has on one—so I gave the child a small handful of absorbent wool, teased up very finely, part in milk food, part in jam sandwiches.

The jam sandwiches were a new experience in the life of that infant, and so the wool went comfortably down. In the evening, some hours later, I ordered a dose of castor-oil; and oh! what joy in the morning. I was greeted at the front door with a copious motion, among which were several egg-shaped lumps of cotton-wool, and in the middle of one of these was the brooch.

I must say I was rather surprised at the complete success of the method—the brooch was so absolutely packed that it was very difficult either to feel or extract it.

Shortly after this episode, I was sent for to see a little boy, *æt.* 4½, who had swallowed a small brass bed knob which he had unscrewed from his bed. Here was something which must, I thought, easily pass along at once. But it did not do so. On the third day a skiagram was taken, and the knob was seen to be still in the stomach, in spite of castor-oil and plenty of food.

An operation was spoken of—apparently that was less serious in the eyes of the sorrowing relatives than that the small knob should rest awhile on its journey south. Aunts kept ringing me up to know if it had "come." An heir to a dukedom could not have been more welcome than that knob would have been had it elected to "come"—but it didn't.

So I set to work with absorbent wool, giving the

child a handful in bread-and-milk, followed at night by a dose of castor-oil.

I did not feel very confident that it would affect the knob one way or the other; it was so smooth; surely, I thought, the wool could not stick, and if it did, would it or would it not cause the knob to be gripped and passed along? I was doubtful.

However, I had the pleasure, when I went to learn the result next day, of digging it out of a mass of *faeces* and wool.

I fancy the wool may act in one of two ways: (1) either by directly enveloping the body swallowed, or (2) by matting the *faeces* together around it.

I hope others will try this method, which naturally commends itself most to one when the body swallowed has sharp points, which require covering, lest they catch and stick in the mucous membrane. But since it will also cover smooth bodies and enable them to be gripped and passed on, I personally feel ready to meet any mother who has a baby who has swallowed anything small enough to pass through the pylorus. This method of treatment has the advantage of being easily and immediately applied, and my results show that it is well worth a trial—for the child is comfortably relieved of its burden, the mother is satisfied, and the doctor should get plenty of kudos, if he has any of the instincts of a conjurer or showman.

[Since writing the above paper, Mr. G. J. Johnston, of Dublin, has called my attention to a successful case of his treated by this method two years ago. His patient had swallowed a metal denture. I can quite believe that wool has been employed frequently, although precise records do not exist except in the above-mentioned case. It is, I think, a method which should be employed, and taught, as a routine practice.]

Transactions of Societies.

ASSOCIATION OF MEDICAL DIPLOMATES OF SCOTLAND.

GENERAL MEETING HELD MAY 24TH, 1905, AT 11, CHANDOS STREET, LONDON, W.

The President, CLAUDE ST. AUBYN FARRER, in the Chair.

THE following cases, illustrating various phases of rheumatism, were shown by members:—

Dr. ALEXANDER MORISON showed three cases of Heart Disease. (1) A girl, *æt.* 9, affected with organic mitral valvular disease, which supervened during the course of chorea without any other manifestation of rheumatism. (2) A man, *æt.* 76, who had suffered from valvular disease of the heart since the age of fourteen, when he had his first attack of rheumatic fever. The attack was also followed by choreiform movements of the right arm, which have persisted ever since as a well-marked athetosis, the condition being probably due to embolism of the cortex. A second attack of rheumatic fever at the age of thirty left the left arm similarly affected, but to a less extent. Dr. Morison showed this case not only as interesting from a prognostic point of view, but also to distinguish the more certainly embolic cases of muscular unrest from the transient choreic cases usually met with, in which he considered an embolic origin was very doubtful. (3) A boy, *æt.* 10, who showed confirmed aortic and mitral valvular disease, due to so-called post-scarlatinal rheumatism, a condition which was to be sharply distinguished from the true rheumatism state, and was probably streptococcal, like the rheumatism following parturition. In the case shown the lesions were double at the aortic orifice and regurgitant at the mitral.

The PRESIDENT showed an interesting case of

RHEUMATISM ASSOCIATED WITH EPILEPSY.

Mrs. L., *æt.* 35, had rheumatic fever fifteen years ago; attack lasted about six weeks or two months; made good recovery; no complications. Twelve months after had first epileptic seizure; these came on about every three or four weeks

after first attack, and from then gradually increased in severity and frequency, having sometimes as many as three or four in a week. This went on for about two years, then patient had another attack of rheumatism, which lasted for some weeks. During this period she had no epilepsy. A medical man attended her for the rheumatism, and she got better, and again at this stage the epilepsy reappeared and continued. I saw her about three years ago, and found her suffering undoubtedly from epilepsy, she having epileptic attacks about every third day. I prescribed ammon. brom., sod. brom., pot. brom., grs. 10 every four hours. Under this treatment she improved, the attacks becoming less frequent, and at last apparently leaving her; but now the rheumatism reappeared and she suffered considerably. This was treated with sodium salicylate, and she improved, only to have a recurrence of the epilepsy, and this alternating recurrence of events has gone on ever since in spite of treatment.

RHEUMATIC RASH.

Dr. DAVID WALSH showed a case of psoriasiform rash which he regarded as a pure manifestation of the rheumatic poison. The patient, E. A., a girl, *æt.* 9, came to hospital complaining of a scaly rash scattered generally over the body and limbs. The spots varied in size from a pin's head to a pea (over the elbows) and here and there to the size of a sixpence. The scales were silvery, and the rash would, some years ago, have been called, at sight, psoriasis. There was some dry seborrhœa of the scalp, and the hair was thin. On inquiry it was found that the mother had suffered from rheumatic fever, and the patient some years ago had a severe attack of rheumatic fever following scarlet fever. Since then she had always been subject to pains in the joints after slight exposure to cold. No valvular lesion of heart. The rash disappeared within a week under the influence of a salicylate of soda mixture. The usual external remedies were applied, but an ordinary psoriasis would have taken weeks or months to cure. Dr. Walsh regarded the skin trouble as a pure rheumatic manifestation. At the time of demonstration, six weeks after the treatment began, there was absolutely no sign or trace of the eruption to be seen.

Dr. G. W. F. MACNAUGHTON showed W. B., *æt.* 63. Enlisted in a line regiment at age twenty-one; served twenty-one years, nine of which were passed in India. During this time he suffered from cholera, dysentery, and enteric. After returning to England, the regiment lay at Aldershot under canvas for three months during the wet season. No signs of rheumatism occurred then, which was in 1888. Twenty years after, the patient, always a temperate man, who had meantime been employed in light outdoor labour, first experienced a grip in the left hip-joint, which caused him to stumble when walking. At intervals, there have been attacks of sudden pain in the joint, becoming during the last eighteen months more frequent, while latterly a constant pain is complained of in the ankle and leg. W. B., has tried all forms of drugs, has been under medical treatment, patent medicines and others, without avail. On examination, the pelvis is tilted, the left superior iliac spine is passing upwards and backwards, the area over the great trochanter is sensitive to touch, the movement of the hip joint much limited, the whole leg is everted, and the patient walks on the outside of his foot, simulating the early position of the second stage of tuberculous hip-joint disease. There is no history of syphilis, there is marked arterio-sclerosis. The condition is one of rheumatic formative osteitis, confined to one joint. It is noteworthy that all the male members of his large family are remarkably strong, the females, without exception, suffer from advanced anæmia, which comes on about the usual period, and persists for years. The mother is a strong, healthy woman.

W. S., *æt.* 40, first suffered from a general attack of rheumatism eight years ago. From the age of seventeen to twenty-one he was a professional short-distance runner and a teetotaler; since then has taken beer from two to ten glasses a day, but never spirits.

Seven years ago the patient had an attack of lead colic twelve months subsequently contracted syphilis with bad secondary manifestations. Since that time attacks of gout have occurred at short intervals. Eighteen months ago the patient was prostrated for thirty weeks with swelling and pain in all the joints of the lower and upper extremities, including the fingers. After medicinal treatment had failed to bring relief, W. S. consumed a pint of stout, and continuing this innovation, he was up on the fifth day, and within a fortnight afterwards was at work. The patient shows gouty deposits upon the left ear and both hands. There is no kidney mischief present.

Dr. S. LIGHTFOOT showed a case of

PARALYSIS OF EXTERNAL PERONEI MUSCLES FOLLOWING RHEUMATIC FEVER.

A. B., a married woman, *æt.* 45, had rheumatic fever twelve years ago, which affected meninges of spinal cord, producing general paralysis of both limbs (hemiplegia), which afterwards recovered from treatment—viz., massage, electricity, &c., with the exception of external peronei muscles of left leg. Fortunately the heart was not affected. Dr. A. Morison recommended tenotomy, fixing foot in plaster of Paris, as this would give a more useful limb, the patient being now handicapped in her movements, as she can only walk very slowly from this great disability. She has been married a number of years, but had only one child live a short period since the attack of rheumatic fever.

GONORRHOËAL RHEUMATISM.

C. D., a married woman, aborted six-weeks foetus three months after marriage. She again became pregnant, and during the fourth month had rheumatic fever, April, 1902, temperature long-continued, and kept at 103° to 105° for some weeks, but subsided to 101° to 103° for a further period of one month and gradually disappeared. There was great pain and swelling in both elbow-joints and wrists, with fluctuations in elbow-joints from fluid and pus. Synovitis of both knee-joints, inflammation of ankle-joints and swelling of both great toe-joints; the right toe-joint discharged a brownish, thick purulent matter. After recovering from acute attack the right arm was ankylosed, as well as left wrist. Adhesions were broken down under nitrous oxide gas on three different occasions—viz., September 29th, October 29th, and November 28th, 1902. This always caused great pain and afterwards joints became rigid again. She, however, went full period, and a male child was born at end of nine months, September 3rd, 1902. She was afterwards operated on by Messrs. Marsh and Bowlby, at St. Bartholomew's Hospital. The olecranon was removed, and the lateral ligaments were severed, producing a flail-like joint (the diseased tissue scraped away), but the surgeons allowed the completely ankylosed wrist to remain, not advising surgical interference. It is now quite solid and curved. This patient, fortunately, had no lesions of heart. During the rheumatic fever there was temporary dilatation of heart. At birth of child it was afflicted with gonorrhœal ophthalmia neonatorum, which was severe and lasted some time.

This was followed by a discussion upon the proposed change of title of Licentiate of the Royal College of Surgeons of Edinburgh to that of Member.

THE PRESIDENT introduced the subject generally, after which a paper was read by Dr. DAVID WALSH (this will be found fully reported on page 609).

THE PRESIDENT'S SPEECH.

This subject of medical titles is an important and far-reaching one. It possibly does not affect the consultant so much as the general practitioner. The man who is more in direct touch with the public and the man whom the public certainly looks upon with a more critical eye, and is discussed as to his qualifications, ability, &c., and upon the verdict they arrive at generally depends his success or otherwise in practice. A section do not consider a man "properly qualified" as they are pleased to term it, unless he is an M.D. of some kind; they are not exactly particular as to where or how it is obtained. Now, to come to

the subject for discussion to-night, that is, that a petition be presented to the Royal College of Surgeons of Edinburgh to alter the title of "licentiate" to that of "member," so as to bring it into line with that of the Royal College of Surgeons of England, this seems to me to be an important thing to bring about if we can only accomplish it, and I see no reason why we should not be able to do so if all holders of the L.R.C.S. will only rally round us and help us. Even the fastidious public wonder that we are only "licentiates" instead of "members." It seems to bear upon the face of it some touch of inferiority to membership, although, as all know, it is not so. My view is, that it is the duty of the College (having granted us this qualification) to put us in the best possible position (as far as our qualification will allow) to take up a professional position *in the eyes of the public* on an equal footing with the Royal College of Surgeons of England. This does not appear to me too much to ask of the body which certainly has our interests at heart. They have always shown themselves ready and willing to help us in any legitimate and reasonable way, if only we will approach them in a proper spirit, and let them see that we are endeavouring to uphold the interests of the College. One main difficulty is (and I am sorry to have to state it) the apathy with which so many men seem to regard their vital interests. It is most difficult to get medical men to take an interest in affairs which are of the utmost importance to them. Others present here, I am sure, will agree with me as to this. They seem quite content to go on from day to day without putting forth the slightest effort to improve their professional status. It is generally left to the few to make a move in such matters. At any rate, this Association has certainly taken the lead in interesting itself in the welfare of its diplomates. It is to be hoped that a petition will now be drawn up and presented by the Association to the Royal College of Surgeons, and this object obtained. I personally have endeavoured to arouse interest in this question by writing to the various medical journals urging upon all whom it may concern to join us and help in bringing about this important object. It is, I know, the wish of all licentiates that the title should be altered. I would ask this meeting to discuss fully and freely the best method by which this can be brought about. At any rate, unity of action is required, and some expense will be incurred. Whether the charter of the Royal College of Surgeons forbids it, I am not certain, but I think not. If it does not, then I am perfectly certain if the Association voices the whole body of licentiates, the petition will be granted. There can be no objection, surely, on the part of the College. There is no need to urge the importance of this matter; it is too apparent. Gentlemen, it depends upon you. Prompt and collective action is necessary. It is not a question of "shall it be done?" but in what manner it can be best accomplished, and the Association of Medical Diplomates of Scotland must do it.

A discussion followed, in which Drs. Lightfoot, Féré, Fitzgerald Powell, Macnaughton, Lewis and others took part.

It was resolved that petitions on the subject be drawn up and presented to the Council of the Edinburgh College of Surgeons.

LARYNGOLOGICAL SOCIETY OF LONDON. MEETING HELD ON FRIDAY, JUNE 2ND.

MR. CHARTERS SYMONDS, F.R.C.S., President, in the Chair.

DR. BARWELL showed a case of "nasal tuberculosis," and a case of "lupus of the larynx and uvula."

DR. CATHCART exhibited a case of "multiple growths" in the epiglottic region in a man, *æt.* 43. These were considered to be growths of the lingual tonsil.

MR. ATWOOD THORNE showed a girl, *æt.* 17, with complete paralysis of the left vocal cord, associated

with dilatation of the left pupil, mitral stenosis, and hypertrophied left auricle.

MR. DE SANTI showed a case of "inspiratory dyspnoea," in a woman, and DR. LACK a specimen of adenoids removed from a man, *æt.* 59.

Other cases were shown by Drs. Kelson, St. Clair Thomson, Lack, and Scanes Spicer.

NORTH-EAST LONDON CLINICAL SOCIETY. CLINICAL MEETING HELD THURSDAY, JUNE 1ST, 1905.

DR. MURRAY LESLIE, President, in the Chair.

THE following cases were exhibited:—

DR. H. F. STAUNTON showed a child, *æt.* 7 months, with a swelling of the shoulder. Three months ago the infant had had a fall, but the swelling had only been noticed by the mother three weeks ago. There was a large semi-elastic swelling occupying the whole of the posterior aspect of the right shoulder-joint. The child had not been vaccinated very long, and there was also an eczematous eruption over the face, scalp, and thorax.

MR. HERBERT CARSON was struck with the extreme condition of tension manifested in the teres major muscle. He was of the opinion that the swelling was an abscess which should be dealt with without delay. At the same time an X-ray photograph would be of considerable assistance in determining the condition of the bony parts about the swelling. The tuberculous nature of the abscess which had been suggested was not improbable.

DR. NORMAN MEACHEN showed a case of Acromegaly in a married woman, *æt.* 43. The symptoms began to appear about eight years ago, and consisted in a progressive enlargement of the lower jaw and the fingers. The patient was cachectic and pale. Prognathism was well-marked, the lower teeth projecting considerably beyond the upper. The fingers were "sausage-shaped" with spade-like extremities. There were no ocular symptoms, and the urine did not contain sugar. The skin was coarse and the trunk was covered here and there with numerous pedunculated warty growths. The tongue was large and flabby. The thyroid gland could just be felt.

MR. CARSON considered that the case bore a resemblance, in many points, to myxœdema. There was no kyphosis, and he was struck with the absence of other body changes. An X-ray photograph would have revealed what tissues of the fingers were hypertrophied. He would be interested to know the effect of the administration of thyroid extract in this case.

DR. A. J. WHITING thought that the fact that the patient acknowledged to feeling better in the cold weather was a strong point in favour of the diagnosis of acromegaly, as also was the typical enlargement of the lower jaw.

DR. J. W. HUNT remarked that the absence of other bony changes by no means negated the diagnosis of acromegaly, and he referred to a case in point.

THE PRESIDENT inquired what treatment had been adopted?

DR. MEACHEN replied that the case had only been under his care for a fortnight, during which time he had simply given iron and arsenic, but that he intended to put her upon small doses of thyroid extract, alternating this latter with pituitary extract. He considered that the prognathism and the presence of signs of epidermic hypertrophy were practically pathognomonic of acromegaly.

MR. CARSON showed a girl, *æt.* 18, with enlarged glands, probably of a lymphadenomatous character. The left axillary glands only were affected, especially those in the anterior fold of the axilla. No other glands were enlarged and the patient's general health was good.

THE PRESIDENT considered that it was comparatively rare to meet with only one group of glands enlarged in lymphadenoma. He thought that mistakes were very frequently made, even by those with wide experience, over glandular swellings. There was often consider-

able difficulty in deciding between lymphadenoma and tuberculous enlargement.

Dr. E. HOOPER MAY thought that in lymphadenoma the constitutional symptoms generally appeared early, whereas this girl seemed in very good health. He advocated thorough and complete removal.

Mr. WALTER EDMUNDS asked if the identity of the two affections, as separate and distinct diseases, were sufficiently established?

Mr. CARSON replied that he intended to remove the mass at an early date, when he hoped to place microscopic sections of the glands before the Society.

Mr. R. PHILIP BROOKS exhibited a microscopic section of an orbital tumour that he had recently removed from the left orbit of a young man, æt. 19. The swelling had been noticed for about a year, and had caused a gradual displacement of the eye downwards and inwards. The vision was unaffected. The edge of the tumour could be felt just below the left eyebrow. At the operation it was found to arise from the lachrymal gland, which was expanded over the tumour, this being just over one inch in its longest diameter. It was encapsuled and no resection of the orbital wall was found necessary for its complete removal. Dr. Basil Price, pathologist to the Tottenham Hospital, reported that the tumour consisted chiefly of adenomatous tissue, but that there were also some spindle-cells present.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, June 11th, 1905.

TREATMENT OF PHLEBITIS.

PHLEBITIS, according to Professor Robin, should be divided into three distinct phases: acute, convalescent, and chronic. As soon as the affection is recognised, the limb should be placed in a box or wire splint, and enveloped with cotton-wool, the leg previously powdered with talc and boric acid.

Talc, 3 oz.

Boric acid, 3 drachms.

At this period ointments are usually applied: mercurial, collargol, iodide of potassium, &c., are of little value; the dry treatment is the best. The patient is prescribed a light diet, of which milk will form the principal part. At the end of three weeks or a month of this treatment the second period begins, when the splint will be removed from the limb, which will be gently rubbed with vaseline and again enveloped in cotton-wool, and laid on the bed for three days. If at the end of that time no pain is felt, nor any rise in temperature is observed, the limb can be freed from all covering, and the following ointment gently rubbed in every morning:—

Fluid extract of hamamelis virg., $\frac{1}{2}$ drachm,
Vaseline, 1 oz.

At this period also massage of the limb can be authorised to excite the general circulation; but it must be done as lightly as possible, and with the palm of the hand only, for five or six minutes daily. For resolution of the phlebotic sclerosis, the following may be rubbed in every evening:—

Ergotine, 1 drachm,
Iodide of potassium, $\frac{1}{2}$ drachm,
Extract of nux vomica, $\frac{1}{2}$ drachm,
Vaseline, 1 oz.

After fifteen days of this treatment, active and passive movements may be allowed, consisting in flexions, extensions, abductions, rotations of the foot.

The treatment of phlebitis terminates with balneation. A bran bath every day for twenty minutes, increased progressively to three-quarters of an hour. After each bath the patient will rest for half an hour, when massage for ten minutes will be done, and after another rest of half an hour the patient can walk about a little. The patient will thus take twenty or thirty baths, but the massage should under no pretext be practised in the region of the large veins: the popliteal space, Hunter's canal, Scarpa's triangle.

To stimulate the nutrition of the atrophy of the

muscles and improve the venous circulation there is nothing better than walking, provided that it be slow and moderate, and that the patient stops when he feels the limb becoming heavy. On the other hand, the patient should be forbidden to stand and to sit down. He should either walk or lie down. During this period it is not necessary for the patient to wear an elastic stocking, a crape bandage (Velpeau) should be preferred.

As to the hydro-mineral treatment of phlebitis, the best waters would be those of Bagnoles de l'Orme, Bagnères-de-Bigorre, Bourbonnes les Bains, Dax and Saint Arnaud.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, June 11th, 1905.

At the meeting of the Society for Surgery, Herr Landau read notes of a case bearing on the

PATHOLOGY AND SURGERY OF OSTEO-MYELITIS GUMMOSA OF THE LONG BONES.

In a girl about the age of puberty there was painful swelling of the right crista tibia, and the lower end of both humeri. The increasing pain and the failing strength led to operative measures, first on the crest of the tibia. After the bone was exposed, the periosteum was found tendinous and thickened, and of a brownish yellow colour, and after turning back this the bone was seen to be of a sulphur colour. A layer was now chiselled off so thick that the bone below was of normal colour. The bone marrow was glairy, and of a greenish yellow colour. A similar operation was then performed on the ends of both humeri. The staphylococcus aureus was found in the bone marrow of the tibia, but not in that of the humeri. Specific treatment was now commenced, and with a perfectly successful result. The disease of the bones must therefore have been syphilitic. The same kind of treatment carried out before an operation had been quite unsuccessful.

Surgical treatment in such cases was called for when the anti-syphilitic treatment had failed to secure any good result.

Hr. Schlosser, Innsbrück, read a note on

PERUVIAN BALSAM AS A SURGICAL REMEDY.

He said that Peruvian balsam had been known in early times, and its curative action in compound fracture had been lauded. He had instituted a series of experiments on animals with a view to gaining more accurate knowledge. A half c.cm. injected into the peritoneum of rabbits had caused no disturbance; in rare cases a slight albuminuria under 1 per cent. was set up. Injected into the tissues large quantities were borne without any ill effect. The doses made use of represented 50 to 70 c.cm. in the peritoneum in man, and 200 to 300 c.cm. into the tissues, more than a tenth of these quantities never being used in practice. Pieces of flesh placed in Peruvian balsam decayed very slowly; it was therefore a favourite material for embalming. Animals injected with garden soil almost always died quickly with sanious phlegmons. If the Peruvian balsam was applied quickly to the wound a proportion were saved. A like result was obtained when the balsam was applied three hours after the receipt of the injury. After these experiments he used the balsam on the human subject, and particularly in uncleaned crushing injuries. It acted well, and no serious inflammations or suppurations took place, although they did occur at the margin, being caused by the mass of necroses. He managed to secure uninterrupted healing after suture of tendons after injuries. In compound fractures of the thigh no suppuration took place. He did not propose it as a rival of aseptic and antiseptic surgery, but for self-inflicted injuries and in the treatment of infected wounds. Thus in animals in which an incised wound was spread over with anthrax bacilli no infection followed. The action of Peruvian balsam lay in exciting a strong leucocytosis. One thing in its favour was its property of "keeping," and another

its long-lasting action. Which of its constituents was the active one was not known. The speaker remarked that balsam of Peru was often adulterated, and he did not know whether the artificial article had the same effect as the real one. He cautioned such of his colleagues as should make use of the drug to make sure that it was the real article.

PSYCHIC TRAUMA AND PROGRESSIVE PARALYSIS.

An interesting case is reported in the *Zeitsch. f. Kl. Med.*, Bd. 55, p. 189. Hr. Kriege, the author, was required to examine a man *æt.* 45, who was a station official, with the object of deciding whether his unfitness for duty was the result of a fright caused by the threats of robbers on July 1st, 1901.

Shortly after the incident the man appeared quite changed to his wife; he seemed to her "strange," his intelligence was diminished. To the question if he felt ill, he answered that he felt quite well. He had done no work since November 7th, 1903, but did not know why he had been pensioned. The examination showed that the patient really suffered from paralytic dementia. Fibrillary twitchings were observed on both cheeks from time to time. The pupils, which were unequal, reacted neither to light nor accommodation. His syllables were indistinctly pronounced. Some questions from the multiplication table were answered correctly, but he could not reckon 11×12 . He had the greatest difficulty in subtracting 60 from 120. In writing down simple sentences from dictation he put a wrong word in one place and in another left out a syllable.

When seen five months later in the City hospital, he was in a state of maniacal exaltation. He ran restlessly around his cell and expressed exalted grandiose ideas. The writer gave it as his opinion that the mental disease had first commenced after the "accident." There were neither subjective nor objective evidences of previous syphilis. The writer gave the following official opinion: That the disease—softening of the brain—had developed gradually and unnoticeably, but that it had not arisen without special cause. The attack by the robbers had given the first impulse, and it might be assumed that without that the individual in question would even to-day be fit for work.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, June 10th, 1905.

TABES DORSALIS WITH ADIPOSIS DOLOROSA.

At the Gesellschaft f. Innere Medizin, Weiss showed the members an interesting case of tabes dorsalis. The patient, *æt.* 5, first complained of ataxic fits with an unsteady gait. Examination gave the Romberg symptom, loss of reflex in the papilla, reduction of the tactile and algetic sensation, which was specially marked on the outside of the little fingers and sixth dorsal segment of the *vertebræ*; ataxia of the lower extremities, but less marked in the upper extremities, while here and there over the body there were parts hyperalgesic.

In addition to these symptoms there was a large crop of small tumours, ranging from the size of peas to that of walnuts, on the fore-arm, thighs, and buttocks. These tumours were ocular, having Volkmann's elastic phenomenon of lipoma. Some of them were subcutaneous, others subfacial in their attachments. The more recent, of two weeks' standing, were tender on pressure, while the older of two years' were painless. They were not symmetrically arranged, as the trunk, face, hands and feet were quite free. Weiss pointed out the painful condition of these fatty tumours, which were so often present as a tropho-neurotic symptom of tabes dorsalis.

TUBERCULOUS TUMOUR IN PLEURA.

Bleier next brought forward two cases for differential diagnosis. The first was a typical case of aneurysm of the *arcus aortæ*, while the other was an obscure tumour in the pleura. The latter was a female, *æt.* 40, who had always enjoyed excellent health up till nine months ago, when she was taken suddenly ill with high

fever and severe cough. After several of these fits of coughing, hæmoptysis appeared. Some time later she began to complain of severe pain in the left shoulder, which radiated down to the finger-ends. During the intervals of relief from pain the pulse was rapid, 160, and very small. After every attack of pain she had an outburst of liquid perspiration. These painful attacks lasted for a few seconds to five minutes at a time, and frequently appeared in rapid succession. Her condition in August was described as slender build, feeble, dulness over left first inter-costal space, pulsation of clavicle and jugular vein; no pulsation in the left radial with decided paresis of the recurrent nerve.

It was then resolved to treat the symptoms and relieve the pain, which was suspected to be due to stenocardia. With this object in view, diuretin, urocedin, and other nitro combinations were administered with considerable success over the pain.

It was next resolved to call the Rontgen rays into requisition, which revealed a dense homogeneous mass extending from the third rib to the apex of the lung. The outline was well defined, taking an outward and upward course to the supra-clavicular space. There was no trace of pulsation when viewed from any point which eliminated the suspicion of aneurysm, which was at one time doubted. By this time the attacks of severe pain were greatly reduced, and more confidence assumed in the use of amyl nitrite, antineuralgine, &c., with excellent effect.

As time went on the objective symptoms began to change, such as pulsation in the supra-clavicular fossa, which became quite marked. Again, the pains increased, which were relieved by the application of the thermophor, with an increase of strength and body-weight.

It was again resolved that Kienböck should make another radiographic examination of the patient. From the third rib to the apex of the lung a homogeneous shadow with its outer margin running outwards and upwards was observed, and still no pulsating or respiratory movements were observed. The vault of the diaphragm was observed to be two finger-breadths higher on the left side than the right, and remained stationary even when forced respirations were made. The heart was drawn a little too far towards the left, and with forced deep inspirations the mesial part moved towards the left. The large vascular trunks were no-where enlarged or dilated. By moving the tube round the morbid mass it was observed to extend from the anterior to the posterior wall of the thorax. It is also important to note that the upper lobe was compressed and airless; the diaphragm and heart elevated, and mediastinal contents forced towards the left. The conclusion arrived at was that the neoplasm was not a distinct tumour or aneurysm in the true sense of the words, but it may be as Askaniy has defined such a neoplasm, as a "tumoid tuberculosis of the pleura." According to this author the pleura becomes enormously thickened and resting on the apex of the lung, compresses the upper lobe and closes the air-cells, while hypertrophic bands of pleura encompass the nerves and large vessels producing the symptoms related above.

In this case the subclavian vein does not lie immediately in contact with the artery, which explains the absence of stasis in the veins. The dulness anteriorly and posteriorly of the left lung is in harmony with the volume of the growth which may account for the pulsation observed later in the history of the case. The artery would be held forward on a hard resisting surface as the neoplasm increased.

Teley asked if he had ever used the exploring needle in this case? Bleier replied that he had inserted it on two different occasions and obtained negative results both times.

Teley said he had recently two similar cases which gave negative results with exploration products, yet the *post-mortem* proved them both to be cancer in the pleura. From the history and results, he was inclined to diagnose the present case as one of the same nature.

Schrotter said this case proved the truth of Skoda's assertion that many aneurysms came before the clinician that were almost impossible of diagnosis. Pulsation is often absent in aneurysms as in the above at the beginning, although present later. The hard bands of pleura explanation was too weak for his reasoning.

Mannaberg did not believe it was a proliferating pleuritis.

Wienberger said the non-detection of pulsation was not proof against the presence of an aneurysm.

Schmidt thought the unilateral pain over the plexus was an early indication of tuberculous due probably to the perineurotic process which has been a prominent symptom in the case from the beginning.

Operating Theatres.

GUY'S HOSPITAL.

OPERATION IN SIMPLE FRACTURE OF THE FEMUR IN A WOMAN, *ÆT.* 72.—Mr. ARBUTHNOT LANE operated on a case of fracture of the left femur at the junction of the upper two-thirds with the lower third. The patient was a feeble edentulous old woman, *Æt.* 72, and of very poor physique. The radiograph showed that the upper fragment presented in two thirds of its circumference a transverse edge, while from the remainder there projected downwards a sharp protruding angle of bone about two inches in length. The lower fragment showed a corresponding aspect. The anterior fragment overlapped the lower by about three-quarters of an inch. Any attempt at reduction was opposed by the projecting spike of bone. As the old lady was feeble and was likely to suffer from the very prolonged recumbency that would be required if any treatment by splinting were adopted, and as the mechanical result of the junction of the fragments, should it indeed take place, in the existing very bad position would be disastrous, Mr. Arbuthnot Lane decided to operate. He exposed the seat of fracture by a long anterior incision and attempted to replace the fragments in apposition by traction, the use of forceps and elevators. This he could not do without using excessive force, so he perforated the anterior wall of each of the fragments obliquely. After introducing a very thick wire through the holes and exerting traction longitudinally upon its ends the fragments were guided into apposition as along two inclined planes. The broken surfaces were then retained immovably in perfect apposition by twisting the wire loop.

The subsequent progress of the case was all that could be desired, the patient being delighted with the freedom from pain consequent on the fixation of the fragments.

SIMPLE SPIRAL FRACTURE OF A FEMUR AT THE HIP-JOINT IN A POSITION OF CONSIDERABLE-FLEXION AND ADDUCTION.—The same surgeon operated by means of a long external incision on a woman, *Æt.* 45, who since she was five years of age had had an ankylosed hip consequent on antecedent tuberculous infection of the hip-joint. The thigh was considerably flexed and adducted. The radiographs showed a typical spiral fracture of the centre of the femur with very great display of the fragments. As it was a matter of vital importance to the patient that the femur should be restored to its old form, and as by no means other than operation that he was aware of could such a result be obtained, he exposed the fragments. Having brought the broken surfaces into perfect apposition he fixed them immovably by means of a screw and silver wire. It was necessary to effect a very strong junction, as owing to the position of the limb it was impossible to use a splint. The dressings were discarded within a

few days and the incision was covered with a collodion dressing. The patient had no pain nor discomfort after the operation, though she suffered much before it.

The progress of the case was uneventful, and the result absolutely perfect as in the last case.

HOSPITAL FOR SICK CHILDREN, GREAT ORMOND STREET.

OPERATION FOR DILATATION OF THE STOMACH IN A GIRL, *ÆT.* 6.—Mr. ARBUTHNOT LANE operated on a girl, *Æt.* 6, for considerable dilatation of the stomach. On examining this organ the pylorus, or rather the stomach in its vicinity, was stenosed by what appeared to be contraction of an ulcerated surface occupying the upper two-thirds of its circumference. The jejunum was cut through at a suitable distance from its origin, the distal end being connected with the stomach at its convexity. The proximal extremity was introduced into the distal portion at a convenient interval below the gastro-jejunosomy. The only objection to this procedure, Mr. Lane said, was the uncertainty as to the cause of the stricture.

The subsequent progress of the case was perfectly satisfactory.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JUNE 14, 1905.

THE SUGGESTED MEMBERSHIP OF THE EDINBURGH COLLEGE OF SURGEONS.

THE recently formed Association of Medical Diplomates of Scotland has abundantly shown the value of such bodies. It has already brought forward and discussed various matters of direct interest to medical men who hold qualifications from the Scotch Colleges. Undoubtedly one of its most important functions is to bring the main body of diplomates into touch with the governing bodies of their colleges. In this capacity the most recent step of the Association may possibly be fraught with far-reaching consequences. It proposes that the title of Licentiate conferred by the Edinburgh Royal College of Surgeons shall in future be either supplemented or replaced by that of Member. Comparing the practice of the Royal Colleges of Surgeons of England and of Ireland,

we find that the English College confers a Membership and a Fellowship, and the Irish College a Licentiate, Membership, and Fellowship. There is no Licentiate in the English College, so that their ordinary diploma is that of Member. On the other hand, the Edinburgh College has no Membership, so that their ordinary qualification is that of Licentiate. There can be no reasonable doubt that this difference in titular distinction handicaps the Scotch Licentiate. The public recognise the difference between the two grades of Licentiate and Member, although the distinction is, of course, more apparent to members of the medical profession. It is certain, again, that the Licentiate is handicapped in competing for many appointments against Members. It is to the removal of these and sundry other drawbacks arising from the lack of a Membership diploma in the Edinburgh College of Surgeons that the Association of Scotch Diplomates have now addressed themselves. The chief arguments in favour of the proposal to substitute and to add the higher diploma will be found set forth in the article that heads the original communications in the present issue of THE MEDICAL PRESS AND CIRCULAR. It is, of course, obvious that the proposal does not greatly concern medical men practising in Scotland, inasmuch as there are comparatively few members of other colleges to be found in Scotland. It is far otherwise, however, with the many thousands of Scotch Licentiates who carry on their profession in Great Britain and Ireland, and who find themselves surrounded by members of other colleges. The removal of this disadvantage, resting, as it does, upon a purely titular basis, would be to them a great and undoubted boon. The request, indeed, seems so just and so reasonable that it is hard to imagine the Edinburgh College will not forthwith take steps to meet the wishes of their Licentiates in various parts of the United Kingdom. We understand a petition is being drawn up by Diplomates of the Royal College of Surgeons of Edinburgh for presentation to the Council of their College. A happy augury as to the result may be drawn from the fact that the Edinburgh Colleges have taken the wise step of combining with their fellow colleges in Glasgow to confer a conjoint double qualification. It may be that the creation of a membership of the Edinburgh College may prove a step further towards the simplification and consolidation of Scotch qualifications. In that case the proposal of the Association of Diplomates of Scotland may have a far deeper and wider significance than that which appears on the surface. So far as we can judge from the arguments advanced, their petition to the Council of the Edinburgh College contains not only a reasonable but also an easily attainable request. The quatercentenary of the Royal College of Surgeons is to be celebrated in July. There could hardly be a more popular or wise a step open to the college authorities than to grace the occasion by the announcement of the creation of a Member-

ship diploma. There is yet time for this to be done, and we commend the idea to the earnest consideration of a corporation whose actions have always in past history been distinguished by a policy of prudence, sagacity, and conciliation.

THE ORGANISM OF SYPHILIS.

FROM time to time, since the bacteriological study of disease came into vogue, announcements have been made of the discovery of the causative organism of syphilis. Disappointment after disappointment has naturally rendered the world of science chary of paying undue attention to further announcements of the same sort, and it is still too early to say whether the recent researches of Schaudinn, Metchnikoff, and Roux will finally be relegated to the limbo of discarded hypotheses. Nevertheless, the results they have achieved, whether they stand the test of time and repetition or no, are the most important published in regard to the subject in recent years. Put in a sentence, Schaudinn has discovered in every one of twenty-six cases of syphilis the same organism, called by him the *spirochæte pallida*; repeating his researches, Metchnikoff and Roux identified the same organism in four out of six cases of men and in four out of six of the apes they had successfully inoculated with syphilis. These facts by themselves, reported by such experienced and careful observers, are all-important, and a careful reading of Metchnikoff and Roux's findings strengthens the case in favour of the spirochæte being the causal organism of syphilis. It has been found in syphilitic lesions and discharges of very various kinds, and has never been seen in other than syphilitic cases, though diseases such as psoriasis, acne, and itch have been examined. In syphilis it was found not merely in the primary sores and in condylomata, but in secondary papules anywhere on the body, and—a very striking fact—in the lesions of congenital syphilis. It appears not merely in the discharge from such lesions, but in the deeper layers of chancrous and mucous patches and syphilitic glands and papules whose surface is still unbroken. It must, therefore, reach such positions, not by accidental infection from the skin, but by carriage in the lymph or blood stream. The fact that the organism has never before been observed in these cases is explained by the great difficulty of staining and demonstrating it. In the unstained preparation it is practically transparent, so that it entirely escapes notice, and it does not take up the ordinary stains. The most suitable stain for demonstrating it is that known as Marino's, which consists of a mixture of azure blue dissolved in methyl-alcohol and a weak aqueous solution of eosin. The *spirochæte pallida* is to be carefully distinguished from another spirochæte commonly occurring on the surface of the genital organs, and demonstrable by ordinary stains. Schaudinn's organism, however, is much smaller, is of corkscrew shape, about fourteen micro-millimetres in length, and perhaps half a

micro-millimetre in thickness. It is unfortunate that there does not seem to be any immediate hope of obtaining cultures of the organism, as up to the present success in the cultivation of spirochæte has not been attained. It will be necessary, therefore, that a large stock of observations should be amassed before the position of Schaudinn's organism is fully established, but with the intense interest that is sure to be aroused by the announcements already made, it can hardly be long before some definite conclusion is arrived at.

VOLUNTARY V. STATE HOSPITALS.

It is only right and natural that the visit of British physicians and surgeons to France should give rise to many discussions and comparisons concerning the relative merits of the way things medical are managed in the two countries. The value of these visits, apart from cementing the good feeling that happily exists between the two greatest civilised powers, lies principally in the demonstration they furnish of the practical workings of systems conceived by minds of different racial constitution. In nothing are these mental characteristics so well illustrated as in the hospital arrangements of Paris and London. The French people are, in genius, essentially logical; every problem that is presented to them is solved on strictly rational lines; practical considerations bear their part, but it is a subordinate one. On the other hand the Englishman is a practical individual with a great, if unexpressed, sense of social efficiency; he does not look to the origin or the end of institutions; all he concerns himself with is the making of the best arrangement for the time being. It is paradoxical, and often provoking, that the Englishman with no fixed scheme or intelligible plan in his head should constantly stumble into a happier position than his Gallic cousin. Such, however, is the case in many important instances. For example, no greater patchwork of anomalies than the British electoral system is in existence, and equally there is nowhere so nicely-calculated and well-proportioned a plan as the French. But while the average life of a French Government is about ten months, in Great Britain ministers seldom stay in office for less than four or five years, and the advantages to this country both in stability of policy and administrative efficiency are sufficiently obvious. So, too, with the hospital system. It needs a particularly optimistic person not to despair of seeing order emerge out of the chaotic condition in which the great hospitals of the metropolis find themselves; the more their disposition, their management, and the relations to each other are looked into, the more bewildered does an intelligent foreigner become—that is, if he wishes to find out the system on which the authorities cater for the needs of the London sick. When it is finally conveyed to him that there is no such system at all, that every hospital authority is a purely voluntary body, and that every hospital

is a close corporation that forges along its own path with complete indifference to the course other hospitals are taking, the intelligent foreigner fails to see how anything but disaster can attend such robust individualism. On the other hand, in Paris, as the visitors from this country have just seen, the hospital system is a vast organisation managed by the Assistance Publique, a Government department which, while relieving the hospitals of fear of financial disaster, does not interfere with voluntary donations and subscriptions which charitable people may wish to give to the sick poor. Moreover, the Assistance Publique is responsible for the external policy of the institutions and their co-ordination of the needs of the public and the capacities of the hospitals, so that all the energies of the staffs of the various hospitals are free to be devoted to the internal work of their own particular institution. Theoretically, such an arrangement is incomparably superior to the happy-go-lucky way in which the sick of the metropolis are provided for, but the practitioners who have recently been in Paris are generally of the opinion that hospital provision and management are not among the "things that they do better in France." It is particularly significant that the most scientifically organised and generously equipped hospital in Paris, namely the Isolation Hospital, attached to the Institut Pasteur, is a purely voluntary institution, maintained by subscription and endowment without any help from the State. The cardinal sin of the French hospitals generally is that they are inadequate in number and in size for the needs of the city, and as every citizen claims, or can claim, a hospital bed as his right in time of sickness, the wards are overcrowded, especially in winter, to an extent unknown in London in modern times. Moreover, the members of the medical staff, being officers of State institutions, find themselves no longer free agents, but practically in the position of civil servants. They receive a salary of ridiculously small dimensions, and in return are called upon to devote a large slice of each day to their hospital work, and on them is cast a great deal of routine work, from which our physicians and surgeons are happily free. The experience gained by the delegates from this country of the working of their State hospital system may well make them advise a pause before definite Government aid is invoked on behalf of the hospitals in London. Chaotic, unsatisfactory, and even ridiculous as the hospital system of London is, the several institutions show, both from the point of view of the comfort and well-being of the patient, and from that of the scientific work of the staff and students, a distinctly better record than that of the French hospitals. And, after all, the proof of a pudding is in the eating.

A SPECIAL Court of Governors of the Middlesex Hospital will be held on June 30th, under the presidency of the Duke of Northumberland, to consider the communications relating to the Medical School received from King Edward's Hospital Fund for London.

Notes on Current Topics.

The Annual Election of the Royal College of Surgeons, England

At the election next month of councillors to the Royal College of Surgeons, England, there will be two actual vacancies, caused by the resignation of Sir Alfred Cooper and the retirement of Sir Henry Howse. Of the two councillors whose term of office has expired, namely, Sir Edmund Owen and Mr. Godlee, both seek re-election. Sir Henry Howse, having passed the president's chair, and having been a member of council since the year 1889, has probably deemed that his official life at the College has been amply discharged. The cause of Sir Alfred Cooper's retirement is, we believe, the fact that he intends shortly to withdraw from the active practice of his profession. Assuming that the two councillors who seek re-election will gain their ambition—a result which usually occurs under such circumstances—keen competition may be expected for the open vacancies. At present only two candidates have begun to bring their claims forward in respect thereto, namely, Mr. Golding-Bird, of Guy's Hospital, and Mr. Harrison Cripps, of St. Bartholomew's Hospital. A recent sad bereavement, however which the latter has sustained may possibly prevent his candidature upon the present occasion. Before the official time expires for candidates to forward their applications there are certain to be several more representative surgeons in the metropolis whose names will be found on the list, more especially as the present opportunity is a good one for testing the probability of success on a future occasion. Experience of past elections has shown that a candidate must be exceptionally popular among the members of his school to be successful on the first occasion that he appeals for their suffrages. Indeed, the election is entirely one in which the personal element predominates. Popularity is practically the only key to success; the late Mr. Luther Holden used to say that he owed every post that he gained to the students of St. Bartholomew's. "They got me appointed assistant surgeon at the hospital, and they elected me to the council at the College" were among those which he especially mentioned.

Police Fees for Street Accidents.

THE need of a liberal uniform fee for medical men called upon by the police to attend street accidents is more or less self-evident. The service thus rendered is skilled, onerous, and responsible to the last degree, and is often possible only at the cost of much trouble and inconvenience to the practitioner. In Glasgow the municipality apparently consider half-a-crown a sufficient remuneration for special service of the kind mentioned. A correspondent to a local newspaper suggests sarcastically that half-a-crown is an extravagant figure for attending to an accident when a Corporation cigar costs no more than a shilling. It can hardly have escaped so acute a writer, however,

that corporations are wont to act liberally when their own personal comforts, luxuries, and commercial interests are involved, but become niggardly when anything is required from medical men. A sermon full of wise philosophy could be preached upon the text of the shilling cigar and the half-crown accident fee. The audience might with advantage be chosen from many places besides Glasgow.

Consent to Operation.

OUR contemporary, *Medical News* (New York) devotes an editorial article in a recent issue (a) to a discussion as to who has the right of giving consent to the performance of a surgical operation in the case of a married woman, and of a minor, respectively. It appears that there is a common belief that the husband has the sole right in the case of a married woman, and that her own wishes are of no importance. This is, of course, a relic of the time when married women were mere chattels in the hands of their husbands, and it has recently been disregarded by the American courts. In a case in the Appellate Court of Cook County, Illinois, it has been held that a surgeon cannot accept the authorisation of a husband to perform an operation on the wife without her consent, nor on the other hand can the husband interfere when the patient's consent has been duly gained. In another case in Maryland it was ruled that "the consent of the wife and not that of the husband was necessary." This view of the law is, of course, the reasonable one, as any other would expose the woman to serious danger if married to a whimsical or unscrupulous husband. In the case of minors, though there is some doubt on the legal point as to whether a child arrived at discretion may not himself give consent to an operation, it is the custom in America as here to refuse operation until the consent of the parent or guardian has been obtained. Of course, in cases of emergency, it is understood that operations may be performed without waiting for consent, and a surgeon incurs no special responsibility by operating in such cases.

The Curability of General Paralysis.

THERE are certain diseases which it is orthodox to believe incurable, and any scepticism toward this belief is, in the eyes of conservative opinion, barely respectable. General paralysis of the insane is usually placed in this category, and the occasional reports of alleged recovery are received with scepticism, and are looked on as somewhat of a reflection on the diagnostic acumen of the responsible physician. It is, however, neither in this nor in similar cases, a logical conclusion to assume that a case is wrongly diagnosed merely because recovery has taken place. It is all a question of evidence, and the diagnosis must be established on clinical grounds, and not roughly abandoned just because the usual termination has

(a) May 6th, 1905.

not resulted. The views, however, of such an observer as Dr. Dana, of New York, have to be treated with respect, and it is interesting to find him coming forward with a report (a) of several cured cases, which he believes to have been correctly diagnosed as general paralysis. He points out that it is an admitted fact that remissions occur in the disease, and he argues that there is no *à priori* reason for believing that retrogression of the disease in the early stages may not also occur, with complete recovery. As the whole question of the justice of Dr. Dana's conclusions depends on the accuracy of his diagnoses, it has to be said that he has not completely proved his case, since, as he himself admits, his evidence of the presence of general paralysis was not quite conclusive. Nevertheless, his cases were of such a nature that they would certainly be diagnosed apart from the sequel of recovery, as general paralysis. Dr. Dana's suggestions, whether confirmed or not, are sure to rouse a spirit of inquiry among others with equal opportunities of observation, and we look for an interesting debate on the subject.

Cranial Pneumatocele.

THE condition known as pneumatocele of the cranium, though accurately described as long ago as 1741, is still to be regarded as of very rare occurrence. Indeed, after a review of the literature of the subject from the date mentioned to the present time, Dr. McArthur, of Chicago has only been able to collect thirty-two reported cases; to these he has added (a) a careful record of a case recently under his own observation. The condition is always due to an extension of the cavity of the frontal or mastoid sinus, so as to allow air to collect between the periosteum and the bone. In all probability, there is some previous atrophy of the bone surrounding the air cavities, and a sudden increase of pressure, due to trauma or other cause, may result in the sudden bursting of the wall. It is noticeable that in twenty of the reported cases there was a distinct history of trauma, while in many there had been inflammatory affections such as would cause weakening of the bony wall. Having once raised the periosteum from the bone, the tumour is likely gradually to increase in size, and the patient may even feel the air passing through when sneezing or other cause increases the air pressure in the nasal cavities. When the tumour has come to a standstill its outline is generally distinctly marked by a ridge of bone an eighth to a quarter of an inch high, due to the continued osteoplastic activity of the periosteum along the line of separation from the bone. Moreover, if the air sac be laid open, or if the tumour be soft enough to be reduced by pressure, the denuded area of bone is usually found to be very rough and irregular with spicules of bone. A careful dissection reveals the fistula by

which there is connection with the air-sinus from which the sac has originated. Treatment, in Dr. McArthur's opinion, presents no difficulties, all that is necessary being to lay open the cavity with aseptic precaution, and by compression produce obliteration of the sac.

The Sale of Poisons for Agricultural Purposes.

THE favourable reception accorded by the President of the Board of Agriculture to the deputation which waited on him recently with the object of obtaining the withdrawal of some of the present regulations on the sale of poisons, seems to point to the possibility of the introduction of a Government bill in that direction. The chief spokesman of the deputation was the solicitor to the Traders in Poisons for Trade Purposes Protection Society, and though an attempt was made to pose as representing the wishes of the public, it was obvious that the deputation was arranged in the interest of those who would personally profit by the removal of present restrictions. Among those who spoke was the manufacturer of a certain insecticide, who has been convicted and fined for selling poisons without a poison label, and without observing the precautions imposed by the Pharmacy Act. It is, of course, natural that persons of this class should wish to be relieved of similar annoyance in the future, but the real question at issue is not the interest of this or that class—agriculturists, seedsmen, or chemists—but the safety of the public. It has been stated that it is not possible in rural districts to obtain such necessary farming accessories as sheep-dips and weed-killers unless general traders be permitted to sell them, but this statement seems very improbable. Chemists are usually men of business foresight whose interests it is to meet a demand of the sort, and at any rate the peculiar case of a few remote districts is not to be taken as setting the law for the land at large. In the interest of public safety we believe that the sale of poisons is at present none too strictly guarded, and if in the future unqualified people are to be given a free hand as vendors of patent drugs, then that safety will be diminished.

"The Irish Medical Directory."

THE Irish Medical Association, at its recent meeting at Killarney, decided by a large majority to discontinue the publication of the so-called "Irish Medical Directory." With this decision we express our cordial agreement, and add our congratulations to the Association for the determination it has shewn to refuse further connection with a discreditable publication. As a prominent member of the Association said, in a recent letter which appeared in our columns: "The little one is so badly deformed that it can only be looked upon by the profession as a monstrous production." Such monstrosities are, however, better hidden from the public gaze, than posing before the public as types of their species.

(a) *Journ. of the Amer. Med. Assoc.*, May 6, 1905.

Their place is in pathological museums where they serve as a means of instruction to the student, and, if they are useless for this purpose, they are buried out of sight. The "Directory" will doubtless experience both fates. Officially, it is buried and its requiem has been sung; actually, a few copies will doubtless be found in medical libraries as a testimony to human perversity and misplaced industry. The fact, however, remains, that the work is gone, and that it is possible again for medical men to join the Association not in order to avoid the boycott, but because they desire to help in the advancement of the Irish Medical Profession.

Professorships in India.

It has often been a matter of wonder to those who view the question impartially that up to the present the Indian Government has not seen fit to make such arrangements for the appointments to professorships in the medical colleges of India as would secure the services of men with a special knowledge of the subject they have to teach. As things stand now, none but commissioned medical officers can be employed, and they are in many cases appointed to chairs for which they have no special fitness and for which they have had no special training. In these countries it is considered that a man should spend many years in the study of a subject before he is called on to teach it, but in India no such training is regarded as necessary. Moreover, even when a man is appointed to a professorship, he does not, as a rule, stick to his subject as a specialty, as do professors in other parts of the world. The same officer may be this year professor of chemistry, and next professor of midwifery or medicine, without having ever undergone any special training in any one of the subjects. It is no discredit to the officers of the Indian Medical Service to suggest that they are not competent—merely *ex officio* and without any special test of knowledge—to discharge the duties of professors in all subjects at the Indian medical colleges. It is right that these officers, if they show fitness for a post, should get the preference over other candidates, but it is not right that other, and in many cases more suitable, candidates should be rigidly excluded. Many of these chairs carry with them emoluments sufficient to attract expert teachers from these countries, and it is unjust that in such cases the Indian students have to put up with what often can only be considered second-rate teaching.

Legislation for Inebriates in New York.

A most astounding piece of legislation is at present under the consideration of the New York State Assembly in session at Albany, which shows how much more advanced business methods are in America than in this country. Many of our readers have probably heard of a mode of treatment for inebriates and other drug-victims known as the "Oppenheimer Treatment," and run as a business concern by a joint-stock company. The

advertisement management of this concern is described by a medical contemporary as "brilliant in conception and Napoleonic in execution," and the terms seem just. Some years ago, by political influence, the treatment was actually foisted upon patients in Bellevue Hospital, and the results were such as to lead physicians to consider that it presented no advance on well known remedial measures in general use. Ever since the company started it has recognised the utility of clerical sympathy, and by presents of shares and other questionable means the treatment has secured the aid of many of the best known clergymen in the States. Others more sincere and equally credulous have followed their lead so that the company has actually boasted of the numbers of its unpaid advertising agents throughout the country, and has attempted to cajole medical men into becoming its "exclusive agents" by the promise of using church interest in favour of their practice. Such methods have naturally created distrust in the minds of respectable people, and many clergymen have, during the past year withdrawn the support they had previously given. That the company is nothing abashed is shown, however, by the legislative effort to which we refer. This is nothing less than a bill providing that magistrates throughout the State of New York shall have the power, if they see fit, to order that any person adjudged an habitual drunkard, or to have committed any crime under the influence of alcohol or other drug, and any inmate of a State institution who is the victim of alcoholic or any drug-habit shall be required to undergo the Oppenheimer treatment at the expense of the State. One can scarcely imagine a more impudent scheme for plundering the public.

Retirement of Dr. Farquharson.

We notice with much regret that it is announced that Dr. Farquharson, who has represented West Aberdeenshire in the House of Commons for twenty-five years, will retire at the end of the present Parliament. Medical members are none too many in the House for it to be able to spare even one, especially when commanding the influence and respect that Dr. Farquharson has gained during his long and faithful service. The lawyer seeking promotion gravitates to Parliament with the same unerring instinct that the duckling takes to water; the doctor as surely eschews it, for the demands of his profession are far too exacting to allow him to serve two masters. The atmosphere of the House of Commons has nothing in common with the sick-room or laboratory, and it takes a determined man who values his mission above his comfort to try to instil a few elementary scientific notions into the heads of the people's chosen representatives. Dr. Farquharson, although enjoying the advantages that pertain to a laird in Scotland, has never forgotten that he is a distinguished member of the medical profession, and has always shown himself ready to support measures for advancing its interests and for safe-

guarding the public health. In his early life he held several important appointments in London hospitals, and the experience there gained has been of great service both to the House and to the country. He will bear with him into his retirement the good wishes and respect of his colleagues on both sides of the Tweed.

Plague in India.

THE outbreak of plague in India in 1896 caused general consternation, and energetic measures were taken by the Government to control and limit its spread. Special officers were sent out, sanitary administration on a large scale was instituted, and vigorous efforts at segregation were made. At the end of two or three years, however, it became apparent that these measures were not being crowned with brilliant success, and after a special Plague Commission had sat and reported on the epidemic, the Indian Government realised that they were faced, not with a local outbreak, but with a vast and insidious distribution of plague that threatened to permeate every province and become endemic. Instead, therefore, of redoubling their efforts, they settled down to a policy of gradual improvement in their normal sanitary service, and the public attention being diverted to the South African war, the interest taken in this country in the plague in India gradually flickered out. But the plague has gone steadily on, and has now reached proportions that can only be described as appalling. In 1903 nearly a million deaths occurred from the disease, in 1904 actually over a million, and this year the mortality goes on at the rate of over 50,000 a week. True, the Government have sent out two investigators, but in face of this mortality one may well inquire, What are they among so many? The disquieting circumstances in connection with the situation is that the Home Government seem to wish to burke discussion on the subject in the House of Commons, for "blocking" motions on the plague in India and the outbreak at Leith have been put down by Mr. Balfour's followers. The only chance of a debate on the subject will be during the discussion of the Indian Budget, when it is much to be hoped that the whole facts will be placed before the country. It is no exaggeration to say that the situation is alarming, and calls for vigorous handling.

Epidemic of Fainting.

A CURIOUS epidemic has been investigated by the *Lancet*. It occurred in the girls' class-room in the elementary schools at Clowne, a small Derbyshire town. The children were noticed occasionally to faint during school-hours, and for some time these isolated cases continued to take place. However, on May 17th, the numbers of individuals affected rose rapidly, till, by May 22nd no less than forty-six had been affected. The school was closed for a day or two, but on being reopened the attacks again showed themselves,

and closure was once more resorted to. The fainting fits were not of an ordinary character, for they lasted for from fifteen to thirty minutes, were accompanied by shivering, spasm, and rigidity, and left the patients very weak. From the report of the county medical officer of health, and the sanitary inspector, it appears that though some slight defects were noticed in the fireplaces, the gas-fittings and drain-pipes were sound, and could not have led to any escape of gas sufficient to have caused symptoms so serious. No carbon-monoxide was found in the air, and mice were not affected when placed in the room. The schools were reopened again, and a boys' class instead of a girls' was held in the suspected room. No cases of fainting occurred. There seems to be little doubt but that after a case or two of genuine fainting an epidemic of imitative fainting fits followed, the poorest girls being the ones to succumb to the influence. The epidemic influence of a case of chorea in a children's ward in hospital is a phenomenon well recognised by old hospital residents, and the screening round of a choreic patient is in many institutions a routine practice. This little Derbyshire outbreak, however, illustrates the care with which such an influence may spread, and recalls the epidemic of dancing mania that broke out in Aix-la-Chapelle in 1374, the memory of which is still perpetuated by the dancing processions which are held on Whit Tuesday at Echternach, in Luxemburg, to celebrate the release of that town from the extraordinary possession of their ancestors of the Middle Ages.

Boric Acid in Food

ALL medical men are averse to the addition of chemical preservatives to food, but when called upon to give evidence in a prosecution for adulteration by such an addition they often find it difficult to support this general opinion by the citation of actual facts. The chief preservatives to which milk and provision dealers resort are boric acid and borax, and it is consequently in regard to these that information is most needful. The United States Department of Agriculture have published in a recent "Bulletin" the particulars of a series of experiments carried out under the supervision of their officers with a view to ascertaining what effect, if any, the addition of borax and boric acid to food produces on healthy individuals. Twelve young men submitted themselves for the tests, and after they had been under observation sufficiently long to determine their proper weight and state of health, they were put on a rigid dietary containing known quantities of these preservatives. Elaborate observations of their condition were made from day to day, no less than 1,175 analyses of urine and 2,550 of samples of food being carried out over periods of thirty to seventy days. Generally expressed, the conclusions arrived at were that boric acid or borax tend to produce a slight loss of weight, which may or may not be recovered during the administration, and that while some individuals

experienced no adverse symptoms under small doses, half a gramme of boric acid, or its equivalent of borax, sooner or later tend to cause nausea, anorexia, discomfort in the stomach, and occasionally headache. The maximum dose that can be safely administered in the course of twenty-four hours is four grammes, but three grammes sometimes were followed by disturbance. The daily consumption of half a gramme of boric acid, or its equivalent in borax, by a healthy person may be continued for sometime, but even this may lead to digestive upset in certain individuals. As the experiments were performed on healthy adults, the conclusion is inevitable that boric acid and borax cannot be given regularly to infants in milk without grave risks.

Appendicostomy.

In a recent issue we made a note of the operation of flushing the colon through a catheter passed into the incised appendix. That proceeding we attributed to a well-known surgeon, but subsequent inquiries point to the fact that the original suggestion was made by Mr. C. B. Keetley, who first proposed appendicostomy as a substitute for cæcal colotomy in a debate at the Medical Society of London, November 12th, 1894. It was soon afterwards performed in the United States by Weir. Appendicostomy has been performed by Mr. Keetley for severe and intractable constipation. He passed a pint of warm water with some saline aperient through the appendix into the colon, a painless and simple procedure that ensures a free motion. Nothing escapes through the incision, as the muscular coat of the appendix probably renders that structure a more or less perfect valve. The same surgeon has also performed appendicostomy after reducing an ileo-cæcal intus-susception by operation. In that case there were three objects in view, namely, in the first place to anchor the cæcum and thus to prevent recurrence; secondly, to favour the recovery of a much bruised and inflamed colon by means of lavage through the appendix, and, thirdly, to prevent shock by injecting suitable remedies. The ingenuity and success of this excellent piece of conservative abdominal surgery reflects a good deal of credit on British surgery.

Regrettable Incidents.

Two inquests, held respectively on June 3rd and June 7th, combine to illustrate in vivid fashion the disadvantages of attending the "splendid isolation" which hospitals like to maintain towards each other. The victim in the first case was a horse-keeper named John Brown, who was kicked on the leg by a horse some three weeks before death. In course of time the leg began to swell and became painful, so he sought admission at the East Ham Hospital. He was refused on the ground that cases of erysipelas were not taken, and he then repaired to the West Ham Hospital, where he was advised to go to another hospital or

infirmary. He was conveyed by his landlady to King's College Hospital, where a like fate awaited him. Eventually he was admitted to the Union Infirmary at West Ham, where he died. The doctor expressed the opinion that his life would have been saved had treatment been vigorously applied at the outset, and naturally the coroner and the jury had some strong remarks to make on the confusion which had brought about the fatal result. The second case was that of the mother of an illegitimate child, who, contrary to medical advice, took the baby out with her on her discharge from Lambeth Workhouse on May 26th. The child became worse and was taken to several hospitals on June 3rd, at all of which hospitals she was refused admission on one ground or another. The officers in one case said that the child was not sufficiently ill, in another that no illegitimate children were admitted, and in a third that a doctor's or clergyman's letter was necessary. After her repeated disappointments, the mother decided to return home, but the child became rapidly worse and died the same day. The death was certified to be from heart failure, due to bronchitis and wasting. The lack of sympathy on the part of the hospitals with each others functions and aims, and we might add the lack of sympathy with the patients, if the newspaper reports are accurate, is regrettable.

Mr. Coroner Troutbeck v. the Medical Profession.

THE long-continued and deliberate disregard of the medical men of his district by Mr. Coroner Troutbeck has at length resulted in the inevitable deadlock. The Wandsworth Division of the British Medical Association, early in the present month, passed a resolution to the effect that in future their members will cease to give any informal assistance to the Coroner of the South-West London district. It is tolerably certain that this example will be followed by the main body of medical practitioners in the neighbourhood. Mr. Troutbeck has himself to thank for this inevitable "lock-out." Things went smoothly enough until he handed over the *post-mortem* examinations of his district to a so-called pathological expert, Dr. Freyberger, and at the same time to a great extent excluded general practitioners from becoming witnesses. His practice then was that under which coroners in all parts of the country work harmoniously with the medical profession. The coroner, before deciding to hold an inquest in a given case, asks the medical man in attendance for private information, and subsequently, if necessary, calls him in to make the *post-mortem* examination and to tender evidence. Mr. Troutbeck, however, has assumed as a right the informal assistance which has hitherto been accorded as a favour. His attempt to supplant the medical men of his district must sooner or later lead to grave scandals, and must also add considerably to the already heavy burden of the ratepayers. In future he may expect no information from the

medical practitioners in Wandsworth, unless they are duly summoned and paid as expert witnesses.

The Central Midwives Board and the Belfast Maternity Hospital.

THAT intolerable body, the Central Midwives Board, has taken one more step on its road to suppression. Like a famous statesman "who never opened his mouth without putting his foot in it," this "unfortunate" Board never appears to be able to come to a decision in a manner which is consonant, not alone with common sense, but even with its own responsibilities and duties. Will it be believed that the same Board which has sanctioned and even schemed for the admission of illiterate and untrained women to the Midwives Roll, which has had its experience and its lesson in the case of the Dublin Maternity Hospitals, and which has transacted its business heretofore in such a manner that it has been described by one of its most prominent members as "unfortunate," has once again opened its mouth and has announced officially that it will not place on the Midwives Roll any woman who has been trained at the Belfast Maternity Hospital previous to April 1st, 1905. From a Board which has committed so many *faux pas* within a short career, no intelligent action is to be expected, but, from any other body, whose procedure was governed by reason, we should expect that, when and if it felt itself obliged to act in a manner apparently opposed to common sense, it would announce publicly the principles upon which it had decided to work. It would then be possible to know, why a Board appointed to improve the training of midwives had refused to recognise those already trained, whilst welcoming those who were not trained, and why many petty English hospitals have been given the concession refused to the Belfast Maternity Hospital. Spite and malevolence have no place upon a public board, or we might be driven to believe that it was the incontestable superiority of the Irish Maternity Schools which had lead this particular Board to adopt the line it has done with regard to Irish trained nurses.

PERSONAL.

LAST week Dr. Curme, of Child Okeford, who is retiring after thirty-nine years of work in the district, was presented with a silver kettle and lamp by the inhabitants. Mrs. Curme also received a gold bracelet.

IN honour of his having won the Derby, Lord Rosebery has given £50 to Epsom Cottage Hospital.

DR. GALLIE, of Canning Town, London, has been the victim of an outrage. While returning home last Tuesday night, he was attacked by two men and robbed of property valued at £60, and left unconscious. One of the men has been arrested.

WE learn that the statement that Dr. G. E. Greene, of Ferns, is a candidate for the post of Direct Representative for Ireland on the General Medical Council is incorrect. Dr. Greene does not intend to come forward himself, but to support the candidature of Dr. Mahon.

THE first Congress of the International Surgical Society will be held in Brussels from September 18th to 23rd, under the presidency of Professor Theodor Kocher, of Berne.

THE Cavendish Lecture in connection with the West London Medico-Chirurgical Society will be delivered by Dr. James F. Goodhart, in the Town Hall, Hammersmith, on Friday, June 23rd, at 8.30 p.m. Subject: "Disease of the Heart."

LORD ZETLAND presided at a festival dinner in aid of the Mount Vernon Hospital for Consumption last week at the Hotel Cecil, London.

THROUGH the generosity of Mr. Eustace Gurney, a very complete electro-therapeutic department is being equipped at the Norfolk and Norwich Hospital.

A DISCUSSION on consumption sanatoria, from the point of design and locality, will be opened at the Royal Sanitary Institute, on Friday, June 16th, at 4.30, by Mr. Edwin T. Hall, F.R.I.B.A.

DR. SEYMOUR TAYLOR presided at the annual dinner of the past and present students of the post-graduate college connected with the West London Hospital, held on the 7th inst., at the Trocadero Restaurant, London.

Special Correspondence.

[FROM OUR OWN CORRESPONDENT.]

SCOTLAND.

PREVENTION OF CONSUMPTION.—At a meeting of the Committee of the Eastern District, Stirling County Council, held at Falkirk recently, Dr. J. C. McVail, Medical Officer of Health, read a report, which had for its subject the steps that might be taken by the local government to prevent the growth of consumption. The report referred to the fact that 580 deaths had resulted from phthisis, and 343 from other pulmonary diseases, in the Eastern District of Stirling within the last fourteen years. A number of plans for the prevention of consumption were submitted in the report, among which was one whereby the authorities would be voluntarily notified of cases of consumption. Also in regard to cases where home treatment would not be convenient on account of the number of inhabitants in the house or from some other cause, the meeting was asked not to lose sight of the fact that it might be possible to utilise the convalescent pavilions of the Fever Hospital, when these might have room as places for the treatment of consumption.

GARTLOCH ASYLUM, GLASGOW.—We made reference a few weeks ago to the apparent harsh treatment of two patients in this asylum by attendants with the result that both patients died. After careful investigation by the Glasgow Lunacy District Board no evidence could be got to convict any of the Asylum employees of harsh or cruel treatment towards either of the unfortunate inmates, Brown or Macfarlane. The matter is now ended as the Crown Authorities have decided to take no criminal proceedings against anyone in the Asylum. In future, it is recommended that all violent or refractory patients should be confined in a separate room, so as not to disturb other patients in the wards.

GLASGOW ROYAL INFIRMARY.—The age limit requires that several of the staff of this hospital retire at an early date. They are Drs. Clark and Knox, surgeons; and Dr. D. C. McVail, physician. At the last meeting of the Managers they were, however, re-elected till end of March next.

APPOINTMENT FOR PAISLEY DOCTOR.—The appointment has recently been made of Dr. J. Jenkins Robb, a Paisley medical practitioner, to be medical officer of Messrs. Cadbury's model village at Bourneville. Dr. Robb was very well known in Paisley, and was a member of the local School Board, and of the Parish

Council there, in which, being on the House Committee, he gave valuable service to the community. He has taken great interest in everything connected with municipal affairs, and the knowledge thus obtained will be of great use to him in his new sphere of duties.

BELFAST.

ACTION AGAINST A MEDICAL MAN.—The result of the third, and it is to be hoped the last, appearance of the case of Tughan v. Darnell is received with much satisfaction in medical circles here. The case was first brought nearly a year ago, to recover £250 damages for personal injuries alleged to have been received by the plaintiff, a minor, owing to the wrong use of belladonna liniment prescribed by the defendant as treatment for an acute orchitis. At the first trial the jury disagreed, at the second they found for Dr. Darnell, and now an appeal against that verdict has been dismissed and the verdict stands. Dr. Darnell, who is a popular member of the profession practising at Bangor, Co. Down, has the sincere sympathy of the medical profession generally in his worry and trouble.

THE WORKHOUSE SANATORIUM FOR CONSUMPTIVES.—The new sanatorium in process of establishment by the Belfast Guardians at Whiteabbey has now been in use for several months, and though only forty patients can be accommodated at present, it is hoped that that number will be largely increased, eventually reaching 200 or 250. The patients at present under treatment are housed in the old dwelling-house on the estate, while the additional patients are to be housed in huts in the grounds. Some difference of opinion, however, has arisen with the Local Government Board who say that when the scheme was sanctioned they understood that all the consumptives in the Union infirmary in Belfast were to be taken to Whiteabbey, whereas it now appears that the guardians only propose to take cases which their medical officers hope to benefit by fresh-air treatment, leaving the more serious cases still in the city.

Correspondence.

THE ABOLITION OF VIVISECTION.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—From an advertisement that has just appeared in the *Times* newspaper, it would appear that in addition to three or four societies for the restriction or prevention of experiments upon animals, there exists a Parliamentary Association for the Abolition of Vivisection. The names of the vice-presidents of this Association include those of many well-known and some distinguished members of both Houses of Parliament. No doubt many more members belong to the Association besides this large number of vice-presidents. Assuming that the case against experimentation upon animals is substantiated on grounds of morality or expediency, the amount of personal effort and of money engaged in the attempt to put a stop to it is certainly greater than that devoted to the mitigation of any equally pressing evil of the present day. But it is surely demonstrable that the anti-vivisection propaganda is based entirely either upon pure falsehood or fanatical distortion of plain facts. That the agitation is doing an immense amount of harm is evident. Not the least unpleasant thing about it is the evidence it affords of the ignorance of many otherwise cultivated men with regard to science and scientific methods, and of the distrust or hatred with which science is regarded by vast sections of the educated public.

I am, Sir, yours truly,
A STUDENT OF PHYSIOLOGY.

June 8th, 1905.

CHEAP MEDICAL ADVICE.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—The medical advice given in some part of the weekly papers must be supplied by some medical man (or woman) and the same applies to the paper

called the *Family Doctor*. Surely the Medical Defence Associations should look into the matter, discover who the delinquent is, and have him or her appear before the Medical Council! The medical man or medical woman (all females being ladies nowadays) who writes for papers, replying to questions with regard to health, and advising (in some cases) treatment should be prohibited from doing so, and convicted of infamous conduct if only for the reason that they defraud the struggling practitioner of small fees, and enable the dishonest seeking cheap advice to save the money (which should by right go to the medical man) for the music-hall or public-house.

I am, Sir, yours truly,

OBSERVER.

[The Medical Defence Unions have enough work on their hands already, but they afford at present the only hope of putting a stop to so gross a breach of professional morals as that indicated by our correspondent. The General Medical Council and the Colleges are not in the least likely to move in the matter.—Ed. M. P. & C.]

HOME AND FOREIGN SPAS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The excellent article on Home and Foreign Spas, in the *MEDICAL PRESS* of June 7th, will be, no doubt, seriously considered by your readers interested in our British resorts. Having in my time visited repeatedly most of the principal continental spas, I should like to supplement your remarks by a few observations. In the first place I would point out that perhaps you hardly lay enough stress upon climatic advantages of foreign stations. It would be difficult to name any of these at which the climate during summer and autumn is not, in regard to sunshine, warmth, and reliability, far superior to that of these islands. Here it is the exception to experience any lengthened spell of fine weather during the warmer months of the year, and the uncertainty of the climate alone at home drives great numbers abroad. Secondly, the superb equipment of many foreign spas gives them an unapproachable advantage over our native places. This is especially the case with regard to the leading German bath towns. Homburg, Ems, Baden-Baden, and Wiesbaden all possess "cure" establishments to which the term magnificent may be truly applied. These were all gradually built during long series of years out of the revenues from the gambling rooms, which up to 1871 were attached to these water cure establishments; and at the same time splendid parks, gardens, and woodland walks were created out of the same resources. Since the suppression of the gaming tables all these delightful accessories—splendid assembly rooms, concert halls, reading rooms, and restaurants have merely needed keeping up. In France and Austria, although the subsidies from gaming tables have been lacking, money has been freely spent during a full century in improving the amenities and attractions of cure establishments in a fashion never thought of in these islands. Next the hotel and restaurant system, although it has been brought up to the highest level in London still remains inferior elsewhere throughout Britain. Then again first rate music is an extremely expensive luxury at home, whereas a fine orchestra which costs a comparatively small sum is easily to be organised abroad. Bad music is intolerable to many invalids of the class that frequent spas and drives many away. Lastly the general dullness of many of our home establishments compels great numbers who might otherwise prefer them to seek abroad the gaiety which they instinctively feel so advantageous in the condition of invalidism for which they seek a remedy.

If the managers of British spas wish to make them more successful they must go and study the details of management of foreign establishments, and, so far as possible, imitate what they there find attractive.

I am, Sir, yours truly,

June 8th, 1905.

UBIQUE.

Literature.

THE CONJUNCTIVA IN HEALTH AND DISEASE. (a)

It was scarcely possible to investigate the diseases of the conjunctiva properly until the advent of the comparatively new science of bacteriology. It may be affirmed that practically all the ordinary affections of this membrane owe their origins to infection by microbes. Notwithstanding, however, all the advanced methods at the disposal of investigators, even now we are very much in the dark. To take one cardinal example: Of trachoma we know absolutely nothing concerning its bacteriology. Inasmuch as the disease is contagious and epidemic, we, *a priori*, assume it to be due to inoculation by germs, but it cannot be said that the existence of any specific organism is *ex cathedra* admitted. It is like carcinoma in this respect. Nature has not yet revealed her secret, or, rather, man has not succeeded in extracting it from her; its discovery, we can only hope, lies in the womb of time.

Mr. Harman, who is known as an indefatigable investigator and careful clinical observer, has made a very conscientious effort to lay before us a concise account of the conjunctiva in health and disease, and he has accomplished his task successfully. The description of the normal conjunctiva is excellent, and the diseases are described in clear and explicit language. The description of trachoma is sound and practical. The book is got up exceedingly well, and reflects great credit both upon publishers and printers. We specially commend the illustrations.

Taken as a whole, the book is certainly one of the most inclusive, best written, and best arranged that we have read on the subject, and should prove of great use to the specialist and general practitioner.

BOSTON'S CLINICAL DIAGNOSIS. (b)

The author of this volume modestly claims that "it does not attempt to furnish more than a working introduction" to a subject which is of growing importance. He has, however, succeeded in the production of a fairly complete laboratory manual which, at the same time, will be of equal service as a clinical companion. The sections dealing with the examination of the blood and urine alone occupy more than half the book, and the methods of examining and the composition in health and disease of these important fluids are exhaustively treated. A good account is given after each laboratory test of its clinical significance. In this manner the volume will be found of great assistance to those who have to undertake the duties of both physician and pathologist, and though in many respects more may be learned by such a combination of offices, yet the tendency of modern specialism and the growth of science necessitate a considerable degree of separation between the laboratory and the bedside. The zoological affinities of the malarial organisms, including the piroplasmata and the pirosona, are described in the section on the trypanosoma, of which there are some good figures. Full directions are given in all cases with regard to practical technique, and the author has succeeded in carrying out his intention of describing only those methods "as can be carried out with a minimum of complicated apparatus." His method of performing the "white ring test" for albumin in urine with a pipette is certainly neat, but it does not appear to us to possess any marked advantage over the time-honoured test-tube method, and in actual practice it would probably be more wasteful of nitric acid. The Bence-Jones's reaction for albumose is fully described, and its clinical significance pointed out. A method is

given for the estimation of chymosin in gastric juice, an absence or marked reduction of which is said to be indicative of carcinomatous or degenerative changes within the stomach.

The importance of a thorough clinical investigation of the faeces, which is only too often apt to be neglected or just casually undertaken, is shown by the fact that nearly seventy pages are devoted to a description of their normal and morbid appearances and constituents. The life-history of the several intestinal parasites is fully given, together with an easy practical method of detecting their presence.

The weakest portions of the book are those on transudates and skin diseases. While cytodiagnosis is described in less than half a page, its special application to pleural effusions is not pointed out, nor is the bacteriology of empyema mentioned apart from a general statement that many different bacteria are found in purulent exudates. The methods of performing lumbar puncture for diagnostic purposes are described and illustrated. No mention is made of the excellent results to be obtained from staining hairs affected with tinea by the modified Gram's method with aniline-gentian-violet, and the drawings of the different varieties of the fungus are somewhat crude. With these exceptions the book may be taken as a satisfactory guide by the laboratory worker.

HEALTH AT SCHOOL. (a)

It is ten years since the last edition of this well-known work was published. During that period many changes have taken place in school management, while school life and work have, to a certain extent, undergone corresponding alterations. In view of these facts, Dr. Dukes has thought fit to issue a new edition of his standard treatise which has for over twenty years been before the profession. The volume, as it now stands is a marked improvement on preceding editions, and is replete with information on every subject likely to interest those who have the welfare of school children at heart. The sanitary arrangements of schools are very carefully considered, and the author strongly advocates an annual sanitary inspection by a man who is practically acquainted with school hygiene. School work and discipline have received due consideration, while exercise and recreation occupy a considerable portion of the writer's attention. Illness in its relation to school life is regarded from every point of view. The duties of the school medical officer are clearly described, and the question of provision of a sick-room and school hospital is fully entered into, while the management of the latter in all its essentials is admirably detailed. The various illnesses incident to school children are briefly discussed, but in a lucid and accurate style peculiar to the author. Among others, the Fourth Disease is described and its points of differentiation from scarlet fever indicated. The desquamation in scarlet fever, so far as the feet are concerned, is stated to be non-infectious, whereas discharge from throat, nose, or ears, so long as that continues, renders the child a source of distinct infection. The first-aid treatment of the commoner school accidents is given in this edition, and will prove helpful even to the professional reader. We have gone over this volume carefully, and have not been able to detect a single dull page in it. Dr. Dukes writes with authority, and if at times he appears dogmatic, it is because he can well afford to be so. Although the volume will prove of greatest interest to medical officers of schools, it will be found none the less useful to the profession generally, who will derive not only pleasure, but also profit from its careful study. This work will long remain a standard one on the subject with which it deals.

(a) "The Conjunctiva in Health and Disease." By N. Bishop Harman, M.A. Cantab., F.R.C.S. Eng., Ophthalmic Surgeon to the Belgrave Hospital for Children. London: Baillière, Tindall and Cox. 1905. Price 10s. 6d.

(b) "Text-Book of Clinical Diagnosis." By L. Napoleon Bos'ron A.M., M.D. Pp. 549. with 320 illustrations. Philadelphia: W. B. Saunders and Co. 1904. Price 18s. net.

(a) "Health at School considered in its Mental, Moral, and Physical Aspects." By Clement Dukes, M.D., B.S. Lond., F.R.C.P., Physician to Rugby School; Senior Physician to the Hospital of St. Cross, Rugby. Fourth Edition, Revised, Enlarged and Illustrated. 10s. 6d. net. London: Rivington. 1905.

PRACTICAL NURSING. (a)

THE writers inform us in their preface that their "great aim in writing this book has been to make the practical part of it as thorough as possible, and to give every step in the performance of the various nursing operations. Not that we for one moment believe that book-work can ever take the place of, or even compete with, ward-work; but we do hold that a precise and complete account of an operation, such as a vapour bath, will aid the nurse in the giving of it, particularly if she should be doing so in private, after having had but little experience of it during her hospital career." These clauses embody so completely our own ideas of the special functions of a text-book on any subject in which theory has to be applied to practice, that we quote them in full. They also convey the authors' notions of the true utility of a scientific text-book, which quite coincides with ours. Reading, of even the best manuals, can never provide the mere reader with requisite skill for the application of his theoretical knowledge; while the unreason of the ignoramus who has just sense enough to perceive this fact, and to make it a ground of defence of his rejection of book-knowledge, deprives him of the capitalised knowledge of all preceding generations of mankind as well as of his intelligent contemporaries.

There are 14 wood-cut illustrations—all of a very instructive type; the two last represent digital compression of the femoral and radial artery respectively, and display the requisite methods admirably. We can recommend this volume as an excellent manual of its subject.

THE TESTING OF SEWAGE EFFLUENTS. (b)

THIS little book, which is intended "to aid borough engineers, surveyors, managers of sewage works, and others not having received a chemical training, in following intelligently the operations connected with sewage purification under their control." Judging from the contents of the book, the addition to the title of "for simple people" would not be unsuitable. To crowd such a big subject into 60 small pages is, to say the least of it, inadvisable, as no one who appreciated the value of chemical analysis at all would think of undertaking such, even with this book at his disposal, if he had not received some sort of chemical training. It is analyses performed by people who have not studied the chemistry of the subject properly that bring analytical chemistry into disrepute, and cause the value of analyses to be ridiculed. Such methods of procedure cannot be too strongly deprecated in the interests of the general public. The author sees fit to disapprove of the standards suggested by the Rivers Pollution Commissioners, because the work could be only done by specially trained persons and not by the manager of the works. We are told that "No periodical analyses by the borough analyst, or occasional examinations by the selected expert, can possibly equal in value the daily observations of the works' manager." We should be glad to know whether the author is not directing his readers to perform an illegal act when he says, "Let a few ordinary goldfish be kept in a globe or aquarium, using only effluent as water supply. If the fish live, and show no signs of distress, the effluent is undoubtedly sufficiently aerated." And then with an almost pathetic touch of kindness towards the poor dumb animals he adds, "It must not be forgotten that goldfish, like other animals, require feeding occasionally."

MOYNIHAN ON GALL-STONES. (c)

THIS book, the author tells us, contains the material

(a) "Practical Nursing." By Isla Stewart, Matron of St. Bartholomew's Hospital, London, and Herbert E. Cuff, M.D., F.R.C.S., Medical Superintendent, North-Eastern Fever Hospital, Tottenham, London. Edinburgh and London: W. Blackwood and Sons. Cr. 8vo., pp. viii. and 436. Price 5s. net. 1904.

(b) "Simple Methods of Testing Sewage Effluents." By George Thudichum, F.I.C. 2s. 6d. net. Pp. 60. London: The Sanitary Publishing Company, Limited. 1904.

(c) "Gallstones and their Surgical Treatment." By G. A. Moynihan, M.S. Lond., F.R.C.S., Illustrations. Pp. 386. Philadelphia: W. B. Saunders and Co.

upon which he based a course of lectures delivered at the Medical Graduates' College in London during April and May, 1904. It includes a detailed account of the etiology, pathology, clinical manifestations, and operative treatment of gall-stones. The subject is divided into eleven chapters and runs to 371 pages. In a careful perusal of the work before us it has occurred to us how very similar many of the allusions and anatomical descriptions distributed here and there through the book are to those cases, figures and notes mentioned in the third edition of a work with a somewhat similar title published last year and written by Mr. Mayo Robson, who, it appears, was Senior Surgeon (now Consulting Surgeon) of the same hospital (the present author being an assistant) and who has for many years devoted a great deal of study and attention to this special subject. We know, in a comparatively speaking new subject, when two authors write much the same about a given organ it is somewhat difficult to vary the description. But still, one does not in the writing of books like to see a too slavish copy of the title, style and scope of a predecessor; or, if followed on similar lines, a reviewer would desire to see here and there a more liberal personal acknowledgment or reference regarding the source from which the previous note, plate, or quotation had been in the first instance derived, particularly as both these surgeons were well known to each other. We can only hope that, should the book reach a second edition, the necessity of calling attention to these inconsistencies will have been removed.

MEDICAL PHILOLOGY. (a)

MR. L. M. GRIFFITHS, of Bristol, has been well persuaded in republishing in a neat little volume the notes on philology contributed by him to the *Bristol Medico-Chirurgical Journal* during the years 1892-1904. They are based for the most part on extracts from the *Promptorium Parvolorum* and the *Catholicon Anglicum*, and, while Mr. Griffiths makes no claim to original scholarship, he has succeeded in gathering together an amount of information which will be found of fascinating interest to medical men interested in the history of the English tongue. There is not a page of the book which will not be found stored with out-of-the-way knowledge, and illustrated by quotations from the less-known passages of the English classics, as well as from works only known to the curious. Notes such as these illustrate in many cases the peculiar change or limitation undergone by the meaning of a word, and also the degradation suffered by words at one time classical, but now banished to the vulgar use only, or to dialect. As an example of the limitation referred to, one may take the word "disease," which was formerly used in the wide sense, its etymology denotes. Thus in Tindale's Bible, Mark v., 35, is rendered "Thy daughter is dead, why desirest thou the Master any further." The word "chincough" now used in certain dialects for whooping-cough appears in Northumberland as "kin-cough," and is connected with the Saxon root, *kink*, to gasp. Mr. Griffiths does not mention that "kink" itself survives in Ireland in the sense of a fit of coughing or of laughing. "Blear-eyed," according to the authorities quoted by the author, originally signified defective sight, rather than rawness of the lids. "Womb," Mr. Griffiths points out, at one time was applied to the entire belly; witness Falstaff, "My womb, my womb, my womb, undoes me!" He might have added that the Scots form "wome" is still used in the general sense. "Tripe" is not omentum, as here stated, but intestine; the plural of this word seems to have become merely colloquial. We trust Mr. Griffiths will satisfy the hope roused by calling the present volume "Part I." and will continue his work to the end of the alphabet.

(a) "Medical Philology," gathered by L. M. Griffiths, M.R.C.S. Eng. Part I., A-EI. Bristol: J. W. Arrowsmith Pp. viii-100, 1905.

NEW BOOKS AND EDITIONS.

The following have been received since the publication of our last list:—

- ALDEN AND Co., LTD. (Oxford).**
The Health of the Nation. A letter to the President of the Local Government Board. By J. Theodore Doid, M.A., with preface by the Rt. Hon. Sir John Gorst, M.P. Pp. 36. Price 6d. net.
- BAILLIERE, TINDALL AND COX (London).**
Laryngeal Phthisis, or Tubercular Laryngitis. By Richard Lake, F.R.C.S. Second Edition, enlarged and re-written by Harold Barwell, M.B.Lond., F.R.C.S.B. Illustrated. Pp. 120. Price 6s. 6d. net.
- The Dental Annual and Directory, 1905. A Year-book of Dental Surgery. Pp. 578. Price 7s. 6d. net.
- A Manual of Midwifery for Students and Practitioners. By Henry Jellett, B.A., M.D., F.R.C.P.I., &c. Illustrated. Pp. 1158. Price 21s. net.
- Mucous Membranes, Normal and Abnormal, including Mucin and Malignancy. By Wm. Stuart-Low, F.R.C.S. One coloured plate. Pp. 60. Price 2s. 6d. net.
- Modern Diets in the Causation of Disease. By J. Sim Wallace, M.D., D.Sc., L.D.S. P. 87. Price 3s. 6d. net.
- JOHN BALF, SONS, AND DANIELSSON, LTD. (London).**
"Verb. Sap." on Going to West Africa, Northern Nigeria, Southern, and to the Coasts. By Alan Field, F.R.G.S. Pp. 154. Price 2s. 6d. net.
- The Maintenance of Health in the Tropics. By W. J. Simpson, M.D. F.R.C.P. Pp. 118. Price 2s. 6d. net.
- Squint, its Causes, Pathology, and Treatment. By Claud Worth, F.R.C.S. Second Edition. Pp. 231. Price 6s. net.
- J. AND A. CHURCHILL (London).**
Psychological Medicine. By Maurice Craig, M.A., M.D. Pp. 449. Price 12s. 6d. net.
- A System of Clinical Medicine. By Thomas D. Savill, M.D.Lond. Vol. I.—Local Diseases and Microbic Disorders. Pp. 702. Price 12s. 6d. net.
- A System of Clinical Medicine. By Thomas D. Savill, M.D.Lond. Vol. II.—Certain General Disorders. Diseases of the Skin and the Nervous System. Pp. 445. Price 8s. 6d. net.
- Paralysis and Other Diseases of the Nervous System in Childhood and Early Life. By James Taylor, M.A., M.D., &c. Pp. 312. Price 12s. 6d. net.
- A Short Practice of Midwifery for Nurses. By Henry Jellett, B.A., M.D., &c., &c. Second Edition, revised and illustrated. Pp. 407. Price 6s. 6d. net.
- A. C. FIFIELD (London).**
Facts about Flogging. By Joseph Collinson. Revised Edition. Pp. 52. Price 6d. net.
- HENRY J. GLAISHER (London).**
Mucro-membranous Enterocolitis. By Paul Froussard, M.D. Edited by Dr. Edward Blake. Pp. 66. Price 2s. 6d. net.
- Anæsthetic Difficulties and How to Combat Them. By A. de Prenderville. Pp. 16. Price 1s. net.
- WILLIAM GREEN AND SONS (Edinburgh).**
An Introduction to Physiology. By L. A. Hodgkinson Lack, M.B. Ch.B. Pp. 215. Price 8s. net.
- Methods of Morbid Histology and Clinical Pathology. By J. Walker Hall, M.D., and G. Herxheimer, M.D. Pp. 290. Price 9s. net.
- T. C. AND E. C. JACK (Edinburgh).**
The Edinburgh Stereoscopic Atlas of Anatomy. Edited by David Waterston, M.A., M.D., &c., &c. In five sections. Price complete, 46 5s.
- J. B. LIPPINCOTT COMPANY (London).**
International Clinics. Edited by A. O. J. Kelly, A.M., M.D. Vol. I., 15th Series. 1905. Pp. 312.
- LONGMANS, GREEN AND Co. (London).**
An Inquiry into the Phenomena Attending Death by Drowning and the Means of Promoting Resuscitation in the Apparently Drowned. Report of a Committee appointed by the Royal Medical and Chirurgical Society. With Plates. Pp. 81. Price 5s. net.
- Exercises in Practical Physiology. By Augustus D. Waller, M.D. F.R.S. Part II.—Exercises and Demonstrations in Chemical and Physical Physiology. By Augustus D. Waller and W. Legge, Symes. Pp. 79. Price 2s. 6d. net.
- Diseases of the Anus and Rectum. Part II, By D. H. Goodsall, F.R.C.S., and Ernest Miles, F.R.C.S. Illustrated. Pp. 271. Price 6s. net.
- E. AND S. LIVINGSTONE (Edinburgh).**
Manual of Diseases of Children. By James Burnet, M.A., M.B., &c. Illustrated. Pp. 406. Price 6s. 6d. net.
- JAMES MACLEHOSE AND SONS (Glasgow).**
A Plea for the More General Use of Tuberculin. By the Profession. By Dr. McCall Anderson. Pp. 56.
- C. ARTHUR PEARSON, LTD. (London).**
The Preparation and Mounting of Microscopic Objects. By Thomas Davies. Edited by John Matthews, M.D., F.R.M.S. New Edition. Pp. 214. Price 2s.
- W. B. SAUNDERS AND Co. (London).**
Diseases of the Blood. Edited by Alfred Stengel, M.D. Illustrated. Pp. 725. Price 21s. net.
- Medical Chemistry and Toxicology. By James W. Holland, M.D. Illustrated. Pp. 600. Price 15s. net.
- THE SCIENTIFIC PRESS, LTD. (London).**
Hints to Nurses on Tropical Fevers. By S. F. Pollard. Pp. 57. Price 1s. 6d. net.
- How to Become a Nurse. Edited by Sir Henry Burdett. Pp. 360. Price 2s. net.
- WILLIAMS AND NORGATE (London).**
THE WALTER SCOTT PUBLISHING Co. (London).
How to Live. By Richard Caton, M.D., F.R.C.P. Pp. 42. Price 3d.
- The New Science of Causation. By H. Croft Miller. Pp. 356. Price 1rs. net.

JOHN WRIGHT AND Co. (Bristol).

Golden Rules of Medical Practice. By Lewis Smith, M.D.Lond., &c. Sixth Edition, enlarged and re-written. Pp. 126. Price 1s.

Obituary.

FRÉDERICK JAMES GANT, F.R.C.S.

ON the 6th instant there passed away at the ripe age of 80 years, the well-known and much respected author of "The Science and Art of Surgery," which reached the dignified position of a third edition, and was considered a scholarly work some twenty-five years ago. Mr. Gant was the author also of several other works, which in his later years of retirement took the form of philosophical disquisitions, and others of a religious character. He held very strong views on nurses and nursing, and his onslaught embodied in the series of articles which originally appeared in this journal under the title of "Mock Nurses of the Latest Fashion," was designed to assist in the re-organisation of the system of which he strongly disapproved, and to compel authoritative registration of nurses in the hope of ridding the nursing community of its undesirable members, and the scandals to which these gave rise. These articles were subsequently re-printed in book form, and attained considerable success. Mr. Gant was for half a century connected with the Royal Free Hospital, London, of which institution he had latterly been consulting surgeon. Before settling in practice, he went to the Crimea in 1854, on the staff as civil surgeon to the British Military Hospitals in the Crimea and Scutari. In later years he filled the office of president of the Medical Society of London, and was a fellow of several of the learned societies. His death was somewhat unexpected, being hastened by an acute attack of pneumonia and heart failure. But a few weeks have elapsed since he published his own autobiography.

DONALD URQUHART MACLENNAN, M.D. ED.

DR. URQUHART MACLENNAN, medical officer of health for the borough of Widnes, passed peacefully away at his residence. He leaves a widow and family, and a wide circle of friends to mourn his loss. Dr. MacleNNan started practice about twenty-five years ago in Widnes, and for the last ten years has been the town's medical adviser. It has been due to him that the borough of Widnes attained the distinction of being one of the healthiest towns in the kingdom. He was educated at Edinburgh, where he graduated M.B. in 1878 and M.D. in 1882.

JAMES BRYDON, M.D. ED., OF HAWICK.

WE regret to announce the death of Mr. James Brydon, M.D., Hawick, one of the oldest and best known medical practitioners in the south of Scotland, on the 5th instant. For two years deceased held the position of Administrator of Anatomy at Surgeons' Hall, Edinburgh. He was gold medallist of anatomy at the University of that town in 1854, and gained many other distinctions during a brilliant college career. He graduated M.D. of Edinburgh University in 1856. His contributions to contemporary literature, both medical and general, were numerous.

JAMES ST. JOHN GAGE PARSONS, F.R.C.S. ENG.
L.R.C.P. ED.

ON Friday, at the advanced age of 87, passed peacefully away Dr. St. John Gage Parsons, the oldest of Bristol doctors. Receiving his medical education at the Bristol Royal Infirmary, St. Bartholomew's and Guy's Hospitals in London, he graduated F.R.C.S. in 1843 and L.R.C.P. Ed. in 1859, and became class director of the Bristol School of Anatomy and Medicine. In the year 1849 he made the discovery of cholera which was then raging in the slums of St. Philip's, and was at that time appointed special cholera medical officer of health, receiving a testimonial from the Mayor and Corporation of the city. He afterwards published a pamphlet entitled "The Reproduction of Cholera and Typhoid Germs External to the Human

Body," which received a great deal of attention at the time, and in the year 1871 the University of Chicago bestowed upon him the Hon. M.D. degree. Somewhat late in life he married a Canadian lady, whom, with four daughters and an only son he leaves to mourn his loss.

JAMES MURPHY, M.A.DUB., M.D., M.B., M.Ch., L.R.C.S. EDIN.

THE respect and esteem in which Dr. James Murphy of Sunderland, was held, was shown by the large attendance at the funeral at Bishopwearmouth Cemetery last week. Dr. Murphy was lecturer on medical jurisprudence at Durham University College of Medicine, and that, and the other institutions with which the deceased had been associated, were well represented. He graduated M.D. in 1877, and L.R.C.S.Ed. in 1878, and took keen interest in all medico-legal matters, being President of the Northern Parliamentary Bills Commission. He was besides an able contributor to the leading medical journals on the subject of obstetrics.

Medical News.

The West London Hospital and Post-Graduate College.

THE annual dinner of the past and present members of the West London Hospital and Post-Graduate College was held on June 7th, 1905, at the Trocadero Restaurant. The chair was occupied by Dr. Seymour Taylor. Among the distinguished guests present were Sir R. Douglas Powell, K.C.V.O., President of the Royal College of Physicians, the Director-General of the Royal Navy and the Director-General of the Army Medical Service. In replying to the toast of "The Imperial Forces," the Director-General of the Royal Navy said that his service owed a deep debt of gratitude to the West London Hospital, within whose walls a large number of medical men in the Navy had acquired fresh experience in the theory and practice of their art. The chairman, in proposing the health of the West-London Post-Graduate College, sketched the progress of the Institution from its infancy up to the present time. It was now the largest post-graduate school in the metropolis. He felt sure that the patients gained materially through the establishment of such a college in connection with the Hospital, while the benefit to medical men was obvious. Thanks were returned by Mr. G. F. Marshall, and the Dean of the College, Mr. L. A. Bidwell, F.R.C.S. The latter remarked that the success of the Post-Graduate College was entirely due to the hearty co-operation of his colleagues upon the Hospital staff. The special classes which had been instituted in the various subjects were much appreciated, and the need for them was steadily increasing. The Chairman's response to the toast of his health, proposed in a graceful speech by Dr. L. Dobson, terminated a most successful gathering.

Medical Temperance Association.

THE twenty-ninth annual meeting of the British Medical Temperance Association was held on Tuesday, May 30th, at the London Temperance Hospital. Dr. Heywood Smith occupied the chair, in the unavoidable absence of the President, Prof. Sims Woodhead. The hon. secretary, Dr. S. S. Ridge, read the annual report, which showed a membership of 568 medical practitioners and 288 medical students, all abstainers. Dr. V. H. Rutherford was elected treasurer in place of the late Dr. T. Morton. A paper by Prof. Woodhead was read, appealing to the medical profession to assist more actively in the promotion of temperance, and it was resolved to ask him to allow this to be printed and issued.

Otological Society of the United Kingdom.

A VERY successful Extra-Metropolitan meeting was held on Saturday, June 3rd, by permission of the Vice-Chancellor, in the Pathological Theatre of the Medical Department of the Victoria University of Manchester, the President (Dr. Thomas Barr, of Glasgow) being in the chair. Cases and specimens were exhibited by Messrs.

Pinder, H. E. Jones, Westmacott, Sewell, Gordon, and Milligan, and papers were contributed by Drs. McBride, Grant, Gordon, Barr, and Messrs. Westmacott, Wilson, Lickley, and Sewell. The most important items of the programme, however, were a paper by Prof. Young and Dr. Milligan, on "The Continuity of the Several Cavities of the Middle Ear," with observations on their development, and on the treatment of acute septic inflammation of the tympanic cavity, and a very fine lecture from Prof. Stirling upon "Otocysts and the Ampullary Apparatus." At 1 p.m. a luncheon was given by Mr. W. Thorburn, President of the Manchester Medical Society, in the Society's Rooms, Owens College, and at 7.30 p.m. the members were entertained at a most enjoyable dinner at the Midland Hotel by Dr. Milligan, which was honoured by the presence of the Vice-Chancellor of the University and the Lord Mayor of Manchester.

A New Ventilating Window-Fastener.

VENTILATION without draught has been the despairing cry of sanitary reformers for generations, and so far this requirement has not been satisfactorily met, notwithstanding many ingenious devices that have come under our notice. We have now before us what is termed "the Lorie reversible ventilating sash fastener," which will probably satisfy the apostles of fresh air, even if it does not come up to the long-sought-for standard of ventilation without draught. The new device, in fact, is another form of securing an open window night and day without the risk of an outsider entering a room. Hitherto this has been attained with the aid of a thumb-screw through the sashes. The "Lorie" replaces this device with a decorated iron plate and fastener, which has the advantage of securing the window against entrance, preventing rattling, and regulating the open space at bottom, top or middle of the sashes in a very simple and effective manner. This contrivance is made by Messrs. Avery and Co., Soho Foundry, Birmingham, and costs but a few pence.

Coal Tar Vinolia Soap.

THE excellent quality of all the Vinolia Soaps is so well known that there is no need to dwell upon their merits here. Their latest product is a Coal-tar Soap of fine quality and appearance, having a very slight alkaline reaction by the ordinary tests. It is a distinct advance on many similar soaps in general use, and can be confidently recommended as an excellent one for use in any condition of the skin where the use of coal-tar is indicated. So far as that goes, it makes an excellent soap for ordinary purposes in the wash-hand-basin, or the bath. It is sold under the name of "Coal Tar" Vinolia.

UPON the recommendation of the Board of Examiners of the R.C.S.E. in Dental Surgery, it has been decided to recognise the licence of the Dental Board of Victoria, and that the holders of such licence should be admitted to the first and second professional examinations of the college together, without being required to pass the preliminary science examination. An alteration has also been made in the regulations for the licence in dental surgery with a view to affording Colonial and Indian graduates and licentiates the same privileges of exemption from portions of the second professional examination for the licence as are accorded to British graduates and licentiates.

IT is stated that since the Paris medical faculty has granted a chemist's licence to Madame Hiron-Thierry, there are sixteen lady chemists practising in France.

THE Mount Vernon Hospital Festival Banquet was held at the Hotel Cecil, on Thursday last, June 8th. The Marquis of Zetland presiding. Among this season's hospital dinners, this is likely to hold the record as £12,670 was the outcome. The institutions at Hampstead and Northwood provide 260 beds, but for lack of funds 120 are closed. An appeal is being made for £100,000.

Notices to Correspondents, Short Letters, &c.

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

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 re-forwarding 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.

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.

G. P. (Nalrn).—The name-plate of the doctor from whom you purchased the practice can generally be retained on the door for longer than twelve months by friendly arrangement with the seller.

DR. H.—We regret our inability to add to our exchange list. It is already beyond our capacity.

DR. S. T. P.—If our correspondent will forward his notes of the case, we will be glad to consider them for publication.

HOUSE SURGEON.—Messrs. Duncan and Flockhart issue a compact little pamphlet on the use of ethyl chloride which, no doubt, they would willingly send on application.

FIFTH ANNUAL SOUTH AFRICAN CIVIL SURGEONS' DINNER.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Through the medium of your journal we should like to call attention to the above dinner, which will take place on Tuesday, July 4th, at 8 o'clock, at the Imperial Restaurant, Regent Street. Mr. W. Watson Cheyne, C.B., has kindly consented to take the chair. Reply cards will be sent to those whose addresses are available, and we hope that those who wish to attend will reply as soon as possible. The price of the dinner will be 10s. 6d. (exclusive of wine).—Yours faithfully,
FRANCOIS E. FREMANTLE (Honorary Secretary).
C. GORDON WATSON (Secretary).

44, Welbeck Street, London, W., June 7th.

EXEMPLARY.—No resident medical officer of a public institution can claim a fee for giving evidence at an inquest held in respect to a patient dying in the institution. The conditions under which a fee of two guineas is paid arise when a person is brought in dead, and when, in such a case, the coroner orders a post-mortem examination to be made on the body. The fee then includes the autopsy and the giving of evidence.

TU QUOQUE.—We have submitted our correspondent's note to the member of our staff who deals with the matters in question, and he informs us that no monograph has been published upon the subject.

DUODENALIS.—No doubt the puffing paragraph was due to the indiscreet action of some lay friend, who thought that by so doing he would do the surgeon a good turn.

ANALYST.—The practice of sending drug specimens by post is not altogether without risk. One well-known case occurred in which a medical man consigned to the waste basket an unopened sample of erythrol tetranitrate. This was thrown in the dustbin and the servant emptied some hot ashes on it, with almost fatal consequences to herself.

DR. H. (Gibraltair).—The Americans have tried a plan of battenin down the hatches and forcing sulphurous acid gas of 18 p.c. into the hold. It penetrates everywhere, and kills not only rats but cockroaches and other vermin, while doing no harm to the cargo.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JUNE 14th.

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

SOUTH-WEST LONDON MEDICAL SOCIETY (Bollingbroke Hospital, Wandsworth Common).—8.45 p.m. Sir R. D. Powell, Bart.: Some Clinical Lessons from the History of Medicine in the Last Half-Century. (Bollingbroke Lecture.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.)—4 p.m. Mr. T. P. Legg: Clinique. (Surgical.) 5.15 p.m. Dr. S. Stephenson: Ocular Therapeutics.

THURSDAY, JUNE 15th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.)—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Dr. D. Grant: The Laryngoscopic Diagnosis of Laryngeal Disease.

MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST (7 Fitzroy Square, W.)—5 p.m. Lecture: Dr. T. N. Kelynak: Demonstration of Cases of Arrested and Advancing Pulmonary Tuberculosis. (Post-Graduate Course.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.)—4.30 p.m. Lecture Demonstration:—Mr. W. Edmunds: Joint Affections in Childhood.

FRIDAY, JUNE 16th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.)—4 p.m. Dr. L. Lack: Clinique. (Throat.)

SATURDAY, JUNE 17th.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN (Children's Hospital, Western Bank, Sheffield).—2.30 p.m. Provincial Meeting Clinical Cases, Pathological Specimens and Papers.

Vacancies.

Down District Lunatic Asylum.—Junior Male Assistant Medical Officer Salary £100 per annum, with furnished apartments, board, &c. Applications to the Resident Medical Superintendent not later than June 12th (See Advt.)

Doctor for Gold Mine in West Africa. Salary £300 per annum, with board, lodging, and passages provided. Applications to Doctor, care of J. W. Vickers, 5, Nicholas Lane, E.C.

Leeds Public Dispensary.—Junior Resident Medical Officer. Salary £100 per annum, with board and lodging. Applications to the Secretary of the Faculty, Public Dispensary, North Street, Leeds.

The Victoria University of Manchester.—Junior Demonstrator in Anatomy. £100 per annum, Applications to the Registrar.

Manchester Royal Infirmary.—Director of the Clinical Laboratory. Salary £200 per annum. Applications to W. L. Saunderson, General Superintendent and Secretary, Manchester Royal Infirmary, South Devon and East Cornwall Hospital, Plymouth.—House Surgeon. Salary £100 per annum, with board, residence, and washing. Applications to P. J. Langdon, Secretary.

Salford Royal Hospital.—Senior House Surgeon. Salary £110 per annum. House Physician. Salary £100 per annum. Junior House Surgeon. Salary £90 per annum, with board and residence. Applications to George Ruddle, Secretary and Superintendent.

Bradford Union.—Senior Resident Medical Officer. Salary £330 per annum, with residence (unfurnished), coal and gas. Applications to George M. Crowther, Clerk to the Guardians, Union Offices, 22 Manor Row, Bradford.

Queen Victoria's Jubilee Institute for Nurses.—General Superintendent: Salary £250 per annum. Applications to the Hon. Treasurer, 120 Victoria Street, London, S.W.

Royal Free Hospital, Gray's Inn Road, W.C.—Senior Resident Medical Officer. Salary £100 per annum, with board, residence, and washing. Applications to the Secretary.

Appointments.

CARDIN, H., M.B.C.S., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Stock District of the County of Essex.

DAVIES, G. H., L.R.C.P. & S.Edin., Honorary Consulting Ophthalmic Surgeon to the Blackburn and East Lancashire Infirmary.

DEWAR, A., M.D., C.M. McGill Univ., L.S.A.Lond., Medical Superintendent of the Royal Hamadryad Seamen's Hospital, Cardiff.

DUNCAN, A., M.D.Lond., Physician to the Western General Dispensary.

ECCLES, W., M.CADAM, M.S.Lond., F.R.O.S., Examiner in Surgery to the Society of Apothecaries.

HEYLIGER, E. D. SCOTT, B.A., M.B., C.M.Glaag., Honorary Ophthalmic Surgeon to the Blackburn and East Lancashire Infirmary.

JONES, T. HENRY, M.D.Edin., D.P.H.Cantab., Education Medical Officer for Surrey.

MANN, WALTER EDWARD, B.A., M.B., B.Ch.Cantab., L.R.C.P.Lond., M.R.C.S., District Medical Officer and Medical Officer to the Workhouse by the Bridport Board of Guardians.

ROBE, A. GARDNER, M.B. (R.U.I.), D.P.H. has been appointed Visiting Medical Superintendent of the City Infectious Diseases Hospital, Belfast.

Birth.

JOHNSON.—On June 9th, at 10 Dryden Road, Bush Hill Park, the wife of Rance D. Johnson, M.R.C.S., L.R.C.P., of a daughter.

Marriages.

BIRCH-MCINTYRE.—On June 1st, at St. John's, Bournemouth, James Guthrie Birch, son of Walter de Gray Birch, LL.D., F.S.A., &c. grandson of Dr. Samuel Birch, F.S.A., &c., of Kensington, to Evelyn Jane, only daughter of the late William McIntyre, L.R.C.P., L.R.C.S., of Odham, and of Mrs. McIntyre, of Bournemouth.

CLARKE-CROSS.—On June 7th, at the Parish Church, Willoughton, Heber Noel Clarke, M.B., of Coggers Hall, Lamberhurst, Kent, eldest son of the late John Heber Clarke, of Abingdon, to Margaret, second daughter of Arthur Bright Cross, of Willoughton, Lincoln.

WARD-THOMAS.—On June 8th, at Lewin's-mead Chapel, Bristol, Percie Overton Ward, eldest son of Dr. J. L. W. Ward, of Glaston, Merthyr Tydfil, to Freda Thomas, only daughter of Harry E. Thomas, of Rockleaze Point, Stoke Bishop, Bristol.

Deaths.

DOUGLAS.—On June 8th, at Guy's Hospital, London, of appendicitis, Cecil Howard, younger son of W. T. Parker Douglas, B.A., M.B. (Cantab.), of Holmby, Speen, Newbury, aged 22.

GANT.—On June 8th, at his residence, 16 Connaught Square, London, Frederick J. Gant, F.R.C.S., Consulting Surgeon, Royal Free Hospital, in his 80th year.

HILL.—On June 8th, at Norris's Hotel, Kensington, Jane Sarah, widow of Dr. Ninian Hill, of Edinburgh and Norwood.

HUGHES.—On June 8th, at Tanfyrnwent, Bangor, N.W., Hugh Robert Hughes, M.R.C.S., J.P., in his 89th year.

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Original Communications.

ABRIDGED CLINICAL REPORT OF THE ROTUNDA HOSPITAL. (a)

By E. HASTINGS TWEEDY, F.R.C.P.I., Master;
AND
GIBBON FITZGIBBON, M.D., and ARTHUR
HOLMES, M.B., Assistant Master.

A VERY remarkable increase in the number of patients treated in both the Intern and Extern Maternity occurred throughout the year. In the former department the increase amounted to 193 deliveries and in the latter to 240. The admissions to the Intern Maternity reached the figure of 2,197. All these occupied beds, and had to be fed and cared for by our nursing staff; 310 were discharged after longer or shorter periods as not being in labour, whilst 1,887 were delivered in the wards of the hospital. The months of May, July, and August show admissions well above 200 per month, and in the first of these 239 women were admitted and 203 delivered. Such numbers were never contemplated by the organisers of our present hospital system, and at times our resources were strained to the utmost. The authorities of the hospital, acting with commendable foresight, have determined on a scheme to enlarge the hospital, so as to still further ensure the safety of our patients and to enhance its usefulness.

The efficiency of a maternity institution is shown more by a low morbidity rate than by an actual mortality. I desire, therefore, at once to direct attention to our results in this respect. Reckoning our morbidity by the method which has been employed in the hospital for years—*viz.*, the rising of a temperature to or above 100° F. throughout the puerperium, we record 159, or a percentage of 8.42 on the total deliveries in the house. These figures compare favourably with the preceding twelve months, in which the morbidity works out at 8.6 per cent. For the sake of comparison with other years we have retained the plan of estimating morbidity, but as a working basis for treatment we have entirely discarded it. It is an arbitrary limit, and differs from the limit of leading Continental Maternities by being two-fifths of a Fahrenheit degree higher, and for it we have substituted the following condition as constituting morbidity—*viz.*, a temperature running above 99 for thirty-six hours, and accompanied by a pulse-rate of over 90 per minute. This, though apparently increasing the morbidity of our hospital, has worked altogether to the advantage of our patients.

Two hundred and two morbid cases have thus been recorded; 91 of these were very slight, and required no active treatment; 26 became normal after one vaginal douching; an additional 25 after a single uterine douching; and 28, being slightly more prolonged,

were given two, and sometimes three, uterine douches before the temperature fell to normal. Blood clots, retained lochia or fragments of membrane, accounted for the majority of these temperatures, whilst others arose from causes other than puerperal. There remain thirty-two cases to record of serious and persistent morbidity.

THE FLUSHING CURETTE IN MORBID CASES.

The routine method now in force in dealing with morbid cases consists in a careful examination for the cause as soon as the symptoms present themselves, and if these are acute the thirty-six hour limit is not waited for. If suspicion is directed to the parturient canal a vaginal douche is administered; if not contra-indicated (a culture for microscopical examination having been first taken) a purgative is given, and the head of the bed raised on blocks to promote free drainage. If symptoms persist on the following day the vagina is again douched out, a Fergusson's speculum inserted, and the cervix wiped dry with sterile wool. Then a sterile glass tube, suitably curved, is passed into the uterus, and its contents are aspirated into the tube by means of an affixed syringe. The tube is next rapidly sealed at either end and sent down to the Pathological Department for bacteriological examination and report of its contents. The uterus is now douched with salt and water, peroxide of hydrogen, or cyllin solutions, according to the predilection of the Assistant Master, whose duty it may be to perform the operation.

If symptoms have not abated within twenty-four hours the patient is transferred, with her mattress and all her belongings, to an isolation ward, where she is taken charge of by a special nurse, and the uterus is again douched. If the bacteriological report has been productive of positive results the inside of the uterus is explored by means of a gloved forefinger in order that pieces of retained placenta, membrane, or old blood-clot may be removed if any such should be present. The treatment differs essentially from the methods employed during the earlier months of my Mastership. Much reliance was placed by my predecessor on the use of the flushing curette, and his views found warm supporters in the assistant masters who were then associated with me. The evidence they were able to adduce in favour of the curette, combined with tight packing of the uterus with iodoform gauze, appeared to be sufficient to permit a continuance of the practice until I could myself personally judge as to its efficiency. My experience of the results obtained by the treatment compelled its abandonment.

The majority of cases no doubt get well under its employment; these are for the most part sapræmic, and would yield readily to any form of treatment. When pathogenic organisms are present it rarely, if ever, succeeds in their removal; on the other hand a grave liability arises that further inoculations and other serious consequences may follow from its employment. Moreover, I have demonstrated by *post-mortem* examination in two cases that the curette fails at times to fulfil its primary object—namely, the removal of adherent pieces of placenta or even of membrane.

(a) Read before the Section of Obstetrics of the Royal Academy of Medicine in Ireland. May 26th, 1905.

On one occasion I employed the flushing curette in an endeavour to remove a piece of sloughing placenta, the exact locality of which I had ascertained by an examining finger; it caused free hæmorrhage, failed even under these circumstances to loosen the mass, and I now look upon its employment in such cases as unjustifiable.

Constitutional treatment was not neglected in any of our serious cases of morbidity; tincture of perchloride of iron in 40-minim doses was administered to all three times a day, and mercurial inunctions, or calomel in small continuous doses by the mouth, was employed in many cases, some of which ended fatally. Stimulants were administered to all, as well as nourishment in large quantities. In one fatal case anti-streptococcus serum was administered immediately on the germ being discovered in the uterus; the results were so discouraging that I feel no inclination to repeat the treatment should occasion arise within the near future.

In one very severe case of pyæmia improvement rapidly followed on the free inunction of Crede's ointment—collargol, 17 grs. to the ounce of lard. The treatment of these grave cases, unfortunately, did not prove uniformly successful, for out of our thirty-two serious cases where morbidity was due to septic infection eight died—three of pyæmia and five of acute septicæmia. One contracted the disease in the month of March, three in April, two in May, one in June, whilst the last case, which occurred in October, was undoubtedly septic on admission to hospital; these months represent our highest percentage of morbidity and the greatest number of admissions.

The changes introduced during the past year include the provision of rubber gloves and finger-stalls for nurses, students and officers of the house, the use of sterilised Gamgee diapers; the providing of a daily change of towels for drying the buttocks; the introduction of a specially designed bed basin, used exclusively by the patient in the bed to which it belongs; the disinfection by boiling of this basin, together with the face-basin and the chamber, as soon as the patient has been discharged and before the bed is again occupied.

MATERNAL MORTALITY.

Thirteen women died in the Maternity Hospital throughout the year. This is an increase of four on the previous year, and even taking into consideration the increased number of women confined in the hospital, the percentage per thousand is higher. In the month of December our first death occurred through accidental hæmorrhage, and the case is so remarkable that I shall report it in full:—

K. M., 6-para, æt. 29, admitted December 30th, 1903; normal pulse and temperature in an early stage of labour; without complication. Two and a half hours after admission sudden and severe external hæmorrhage appeared, the assistant master at the time being in the ward. The patient was immediately prepared for examination; the os admitted one finger and the vertex presented; no placenta to be felt. The vagina was tightly plugged and the binder applied in the usual manner, great collapse supervening before the operation could be completed. The usual well-known methods for combating collapse were resorted to, but despite these the patient's condition became distinctly worse, and her pulse could be felt with difficulty at the wrist an hour and a half later. This seemed clearly to indicate the hæmorrhage, though not appearing through the plugs, was nevertheless being poured into the uterus; the plugs were therefore removed, but to our surprise we found that this was not so, the amount of free blood not being greater than could be accounted for by that which was poured out during the process of plugging.

The membranes ruptured whilst the plug was being removed, and it seemed to me advisable, under the circumstances, to perform combined bi-polar version. This was accomplished with the utmost ease, and occupied but a few moments. Several pints of saline infusion were injected into the cellular tissue, this, combined

with stimulants, and raising the foot of the couch, caused the patient to rally for a time. During the succeeding four hours no hæmorrhage occurred, and she seemed to make satisfactory progress towards recovery; then a sudden change for the worse took place, and she failed to respond to our utmost efforts at stimulation. Delivery of a dead child was completed whilst the patient was moribund. No light was thrown on this case by the autopsy. The uterus contained no blood.

Case II. is also of great interest. A. T., 5-para æt. 28, admitted January 21st in labour; pulse 108; temperature 99.2°. The head was freely balloting, above the brim, and the history of the last delivery, which occurred in the hospital, was that of a difficult forceps through an insufficiently dilated os. Three hours after admission the head was still freely balloting, and a vaginal examination demonstrated the os to be a little more than half dilated; during this examination the membranes ruptured with great force. Some hours later, the pains having decidedly weakened in character, my late senior assistant thought it advisable to attempt the application of forceps. Failing to deliver by these means, and having diagnosed a low insertion of the placenta, he turned and brought down a leg, and retired to bed, believing that the patient would deliver herself.

On the following morning the patient wore an anxious appearance, and labour pains had entirely ceased. I proceeded, therefore, to deliver her—a dead child being born. On examination the vault of the vagina was found to be extensively torn, the tear involving the lower uterine segment in a lateral and transverse direction. I removed the uterus by abdominal hysterectomy an hour and a half later. The patient never properly rallied, and died on the fourth day.

INDUCTION OF PREMATURE LABOUR.

This operation was performed in all five times throughout the year.

Case I.—A. M., 7-para, æt. 42, was seen in the dispensary six weeks before admission to hospital, and then complained of loss of power in the lower extremities, with pain in the back of three weeks' duration. This loss of power had become absolute on admission. She suffered from incontinence of urine, loss of rectal control, and a bed-sore formation on the buttocks. The knee-jerk was present in the right, absent in left leg; ankle clonus and the plantar reflexes were absent; Babinsky's sign was well marked. Tactile sensation was present, but the sense of pain was lost over the lower extremities and over the abdomen. She suffered from cystitis, with pus in the urine.

Two bougies were introduced into the uterus three days after admission. On the following morning the cervix was dilated up to 7 centimetres by a Bossi's dilator, fresh bougies were then placed in the uterus, accompanied by iodoform gauze plugging of the cervix. On removal of these, in twelve hours, the vagina was tightly plugged with cotton-wool. In another twelve hours labour had started, and was completed naturally, a living child being born. It breathed feebly, and died soon afterwards.

The patient regained slight power in her legs on the following day, and movements were fully established by the third day; sensation returned on the seventh day, and rectal and bladder symptoms had disappeared in a fortnight. On the nineteenth day she left hospital completely cured. A diagnosis of acute neuritis was made.

Case II. is remarkable for the complete and prolonged absence of labour pains after rupture of the membranes:—E. H., 3-para, æt. 31, was admitted on July 18th at full term with the membranes ruptured. She was kept under observation for five days, and then, as no uterine action had taken place, three bougies were passed into the uterus. These were removed in twenty-four hours; the cervix was then dilated with Bossi's dilator to 5 centimetres and plugged with iodoform gauze. In another twenty-four hours feeble labour set in, the woman being finally delivered by

means of forceps of a dead child, with a well-marked spina bifida.

Case III.—M. M., 7-para, æt. 32, was sent up from the country nine days before full term to have labour induced for a slightly flattened pelvis; conjugata vera 9.5 centimetres; all other measurements normal. Premature labour had previously been induced successfully in the Rotunda Hospital on several occasions.

Having regard to her closeness to full term and the comparatively slight degree of contraction, I determined to let her await normal labour. This had not occurred four weeks after admission, and her great size, together with the accurate dates she was able to furnish, made it highly probable that we had to deal with a case of prolonged gestation.

Similar means to those detailed above were adopted to induce labour, but they failed to excite pains at the end of forty-eight hours. An ounce of sterilised glycerine was then injected into the uterus, and was followed by the rapid onset of labour pains. At the expiration of thirteen hours the os was fully dilated and the head fixed in the brim to an extent that induced my assistant to believe that delivery with forceps could easily be accomplished. This proved an impossible task, the blades slipping from the head on two different occasions.

The absence of fetal heart-sounds contra-indicated the performance of symphyseotomy or further delay in the hope of obtaining better moulding of the head. Internal podalic version was accordingly performed, and a dead child, weighing 10½ lbs., was extracted with difficulty.

Delivery by craniotomy had been accomplished in her four first children; her fifth child lived for a few moments, and was delivered by forceps; in the sixth and seventh labour was induced just before full term—living, large, and fully developed infants being born.

Case IV.—M. O., 16-para, æt. 40, had labour induced because of extensive and severe kidney trouble of six weeks' duration. Her symptoms included severe œdema, albuminuria followed by hæmaturia. Dr. F. C. Crawley kindly examined her eyes for me, and diagnosed albuminuric retinitis and optic neuritis. All her symptoms having increased in severity during the three days in which she was under observation in the hospital, labour was easily induced by the passage of three bougies into the uterus. Delivery followed in three hours, and she was discharged on the twelfth day from hospital free from œdema and with a normal temperature, but with persistent albuminuria.

ACCIDENTAL HÆMORRHAGE.

Among the thirteen cases of accidental hæmorrhage one ended fatally and is fully recorded under the heading of "Mortality." Nine of those cases required no treatment, as the patients were in good labour and the hæmorrhage not severe enough to warrant interference; in the others labour had not commenced. In these, moist aseptic pellets of cotton wool were inserted in the vagina, and packed tightly round the cervix after a preliminary disinfection. The plugging in each instance was then continued until the vagina became completely filled. A diaper placed between the legs and a tight abdominal binder applied from above downwards completed the operation. It is unnecessary and mischievous to place a bullet-forceps on the cervix when performing this operation, for the plugs can be readily applied by the aid of the left hand passed into the vagina, with its palmar surface pressed against the posterior wall, so as to make a wide and simple retractor or speculum. During the performance of this the patient is preferably placed on the left side.

I feel more convinced than ever that the circulation in the uterine arteries can be directly impeded by pressure exerted on them by the vaginal tampon. The fact that even in fatal cases the uterus has not been found to contain more blood than can be accounted for by the amount poured out during the application of the plug sufficiently answers the theory that intra-uterine tension due to the outpouring of blood into the uterine cavity suffices to prevent further flow.

PLACENTA PRÆVIA.

There were only four cases of placenta prævia, with one death, due to septic infection. This woman was plugged by a practitioner before being sent into hospital; she fainted several times whilst coming a distance of nine miles in a cab, and reached us in a deplorable condition. Bi-polar podalic version was easily performed, and she gave birth to a dead child two hours later by natural efforts.

On the fourth day her temperature rose to 101° F. The following day to 102° F.—on this evening cultures taken from the vagina and uterus contained streptococci. She died of acute sepsis on the eleventh day.

Bi-polar version was performed in all other cases, and in one a living child was born sixteen hours after performance of this operation, a proof that the life of the child is not necessarily sacrificed by its prolonged stay in the parturient canal after a foot had been brought down with the membranes ruptured.

POST-PARTUM HÆMORRHAGE.

In none of the twenty-nine cases recorded under the above heading was there any effort made to weigh the quantity of blood lost, and so estimate the severity of the disease. A method such as this, even were it practicable, would fail in its object because of the impossibility of ascertaining beforehand the amount of loss that can with safety be sustained in a given case.

Our diagnosis rested on the presence of a continuous flow which natural processes were insufficient to check, and which, if permitted to continue, would inevitably result in the supervention of constitutional disturbance. This seems to me the only practical means at our disposal for determining the condition.

We divide these hæmorrhages into three distinct classes:—

- (1) Traumatic, the result of tearing of the soft parts.
- (2) Pseudo-atonic, due to inefficient uterine retraction, the result of mechanical obstruction or misplacements.

- (3) Atonic, a condition of great rarity.

All our cases were successfully treated as follows:—External manual massage and ergot in eight cases; in a further three a hot vaginal douche, with bi-manual massage to the uterus. In eighteen cases the uterus was unable to retract because of mechanical causes; adherent placenta was present in twelve, and blood clots, associated with retained membranes, in six. All save one of these were promptly arrested on the manual clearing out of the uterus, followed by a hot uterine douche; the remaining case necessitated the plugging of the uterus with sterilised gauze bandages three inches wide and six yards long.

There remain to be mentioned two cases of secondary *post-partum* hæmorrhage—one, M. W., occurred on the eighth day in conjunction with septic infection; the other case had a normal delivery, with a torn perinæum, which was united by one suture. Six hours later the patient was discovered to be bleeding, the cause of which was found, on close inspection, to be due to a spouting vessel in the perinæum.

MANUAL REMOVAL OF THE PLACENTA.

Manual removal of the placenta was performed thirty-six times. Thirteen of these cases showed a more or less morbid temperature within two days. Three more developed morbidity, but not of a severe kind, after the fifth day. In six *post-partum* hæmorrhage was the indication, while in thirty-one adherent placenta was present, and in five retention was due to spasm of the uterus. In my opinion this latter complication should not be met with so frequently as we have seen it, nor should it call for forcible removal of the placenta save in the presence of dangerous hæmorrhage. Rest, combined with hypodermics of morphia, will in time bring about relaxation of spasm, and so enable the uterus to empty itself by natural efforts.

The employment of gloves, together with the repeated introduction of the gloved hand into the uterus, until every particle of adherent tissue has been

removed, will, I feel sure, greatly lessen our morbidity in the future.

ECLAMPSIA.

We had no fatality among our eight patients who developed eclamptic fits. Five of these were primiparæ, two two-paræ, and one three-paræ. All were œdematous and suffered from marked albuminuria.

The fewest number of fits was two, and the greatest eleven. In two the convulsions were altogether *post-partum*, and in two they were of the mixed variety, occurring both before and after delivery. Macerated children were born in four of the cases. In one instance forceps were applied, whilst labour was terminated by natural efforts in all the other cases.

In treating this diseased condition the Dublin method was strictly followed. This consists of a rigid adherence to many points of detail. The patient is kept on her side to prevent fluids formed in the mouth from reaching the lungs by inspiration. For the same reason croton oil or other form of medicine or fluid is not permitted to be placed in the mouth of an unconscious patient. I feel convinced that the so-called œdema of the lungs, which is said to close the existence of many eclamptics, results in reality from such mistaken methods of treatment. Neither vapour baths, pilocarpin, nor other form of diaphoretic is administered, for the advantage derived from each and all seem very problematical, and are constantly more than counterbalanced by their other objectionable effects.

We pass a stomach-tube through the mouth in the event of our patient being deeply unconscious, and through the nose if she be in a state of semi-consciousness. In the former condition the soft palate fails to respond to the stimulation of the nose-tube, and the latter is in consequence much more likely to be passed into the trachea than through the œsophagus. By means of this tube the stomach is thoroughly washed out. Into the stomach is then poured, by means of the tube, a quart of slightly saline hot water, together with castor oil, elaterin, croton oil in four or five drop doses, or some saline purgative, according to the predilection of the operator.

Whilst these preparations are being perfected a hypodermic of morphia in a $\frac{1}{2}$ -grain dose is injected; this drug is repeated every two hours in $\frac{1}{4}$ -grain doses until the fits cease or until a grain has been administered. It is occasionally necessary to continue the administration of the drug, but on no account should a greater dosage than 2 grains be administered in twenty-four hours.

We attach enormous importance to the thorough and rapid evacuation of the bowels, and the purgatives are stimulated in their action by the administration of copious enemata of soap and water with castor oil. Saline enemata are also given.

In severe cases normal saline, to the amount of two or three pints, is infused once, or oftener, into the cellular tissue beneath the mammary glands. Labour is never induced, nor is its onset to be desired. Should it unfortunately occur its progress is seldom interfered with. In the one case in which we departed from this rule the convulsions seemed to be rather aggravated than diminished by the complete delivery.

CÆSAREAN SECTION.

M. H., æt. 29, 1-para, sent into hospital because of her small size and abnormal shape before labour had set in. Her pelvic measurements were Cv., 8 cm.; t, 13 cm. Labour set in on the third day after admission. The head showed no sign of fixing twelve hours after commencement of labour, and was found to markedly over-ride the symphysis pubis. It was perfectly apparent that a sufficient amount of moulding could not be brought about by natural efforts to permit the head to pass through the brim, and Cæsarean section was performed. Both child and mother left the hospital in complete health on the fifth week from delivery.

The operation of Cæsarean section must be considered among the easiest and safest of abdominal sections when performed under the favourable condition which obtained in this case. A very interesting point which was noticed in this, as well as in all my other

similar operations, was that the uterine wall thickened rapidly during the process of suturing, and that this thickening occurred quite independently of uterine contractions—a proof that the processes of retraction and contraction are not dependent one upon the other, and that a uterus, though in a relaxed condition, can retract, and so prevent *post-partum* hæmorrhage.

The foregoing report also included brief references to seven cases each of "prolapse of the uterus" and of "hydramnios," a serene case of "hypermesis gravidarum," one of "symphyseotomy," and one of "craniotomy," abortions and immature deliveries occurred in sixty cases, and among the infantile conditions four cases of imperforate anus were met with, in all of which the obstruction was relieved by operating through the perineal route.

THE TREATMENT OF INGUINAL HERNIA IN INFANCY AND CHILDHOOD.

BY R. C. DUN, C.M., F.R.C.S. ENG.,

Surgeon to the Liverpool Infirmary for Children.

THE great frequency with which inguinal hernia occurs during infancy and childhood makes the question of its treatment one of interest and practical importance. In selecting this subject for my paper I may, possibly, bring upon myself the criticism that the many questions involved have been already thoroughly thrashed out, and that the line of treatment which should be adopted has long ago been definitely laid down. In spite of this I shall venture to give you the results of my own practical experience, which has been, for the most part, obtained in the wards and out-patient department of the Liverpool Infirmary for Children.

Referring to the records of the Children's Infirmary for the past six years I find that the annual average number of cases of reducible inguinal hernia which have sought advice has been 236. The bulk of these cases have, of necessity been treated as out-patients, a circumstance which has rendered it difficult to keep detailed notes of treatment and progress. I have however, been able to collect complete case records of just over 200 patients. The notes have either been taken by myself or by my house-surgeons. It is upon these definitely ascertained facts that I base my paper.

Reviewing a few points in the history of this series of cases which bear upon the treatment, I find that 97 per cent. of the children affected were males, and that 70 per cent. of these boys were ruptured on the right side. The formation of the peritoneal process associated with the descent of the testicle must therefore be looked upon as the main predisposing factor in the production of these hernia. The later descent of the right testicle, with a consequent diminution of time for closure of the peritoneal process before birth, accounts for the preponderance of right inguinal hernia.

Under normal circumstances the peritoneal process, or funicular process as it is usually termed, is closed at birth. In a certain proportion of my cases, 12.5 per cent., obliteration of the funicular process had not occurred, and the ruptures were noticed immediately after the child was born. In a much larger percentage of cases, 60.5 per cent., the ruptures appeared at some date between the end of the first week and the end of the third month of life. In these cases we have to look for some exciting cause which by increasing abdominal pressure has led to dilatation of a recently or imperfectly closed funicular process.

From the end of the third month up to the twelfth year I find that the herniæ appeared in only 18 per cent. of my patients. This I would account for by the fact that at the third month the funicular process has become firmly sealed, and that the increased length and obliquity of the inguinal canal offers a more efficient barrier to the effects of increased intra-abdominal pressure.

(a) Read at the annual meeting of the Lancashire and Cheshire Branch of the B.M.A. at Blackburn.

Returning to the series of cases in which the ruptures were not present at birth but appeared from the second week to the third month, we find a number of conditions present which may, I think, be fairly considered as definitely exciting causes in the production of the hernia. Out of my total of 121 cases in this group gastro-intestinal disturbance, as indicated by vomiting, flatulence, diarrhoea, or constipation, was present in 42. In the majority of these children artificial feeding, generally with one of the patent foods, had been adopted; while it was frequently ascertained that in the so-called breast-fed children, some additional and usually unsuitable article of diet was given on account of the child "not being satisfied." In 9 out of the 121 cases the ruptures had come down first while the child was suffering from a severe cough. Phimosi and preputial adhesions I found present in 89 cases. There is some diversity of opinion as to whether this condition is one which plays an active part in the production of hernia, or whether it is to be merely looked upon as an example of associated congenital deformity. Certainly it is unusual to meet with cases in which there is actual obstruction to the outflow of urine, but in the majority irritation from retained secretion may well account for fretfulness, crying, and straining—all of them increasing the abdominal pressure and so tending towards the production of hernia. In two cases in infants I could ascertain no other exciting cause than the too tight application of binders. In both these the ruptures were small and both disappeared without treatment when the mothers were shown how the binders should be put on.

In older children I have found similar exciting causes at work, and in addition the presence of intestinal parasites, vesical calculus, and sudden strain.

Imperfect descent of the testicle has been associated with hernia in 13 out of all my cases noted. The presence of a testicle in the inguinal canal and its constant movement caused by the contraction of the abdominal muscles cannot fail to altogether prevent, or at any rate retard, the closure of the peritoneal process and so predispose to hernia.

Two factors, then, lead to the production of inguinal hernia in infants and children; first, and always present, an imperfectly closed or actually open funicular process of peritoneum—the predisposing cause; secondly, and present in the majority of cases, some exciting cause which by increasing the intra-abdominal tension forces some abdominal content into the peritoneal pouch. The treatment of hernia occurring during the early years of life must, therefore, to be successful, be directed against both the exciting and predisposing factors giving rise to the condition. I may say at once that I believe there is a great tendency to concentrate all our energies in attempting to obliterate the funicular process and to neglect altogether, or at any rate to minimise the importance of the treatment of those exciting causes which are keeping that process open.

Coming now to the question of actual treatment, my first rule has been to ascertain by careful inquiry and examination whether any definite exciting cause exists. Should any be found I proceed to treat it vigorously. In the event of gastro-intestinal disturbance being present, in nine cases out of ten some fault in the feeding will be manifest and a scientific feeding prescription will do far more good than drugs. Particularly in the case of marked constipation there is a tendency to trust too much to medicine and too little to dieting, the importance of a sufficient quantity of fats administered, suitable fruits and vegetables in older children, and abdominal massage cannot be over-estimated. If very marked gastro-intestinal symptoms are present I think that it is advisable to ameliorate them even before truss treatment is adopted. In slighter cases a truss may be ordered at once and the treatment of the exciting cause of the rupture continued during its use. Operation is, of course, out of the question if the child is not in good general health.

As regards phimosi and preputial adhesions I consider it advisable to operate, either circumcising or

breaking down adhesions, before a truss is applied or operation on the hernia carried out. I never neglect these simple and common conditions because I feel certain that every baby or child who suffers from them, even when unassociated with hernia, ought to have them put right. Another reason is that the ruptures in quite a number of cases do not come down so soft or to such an extent after the cure of phimosi or preputial adhesions, and therefore truss treatment is likely to be more successful after their cure.

It is useless to predict a cure of the hernia from a circumcision, though on general health grounds and the improved chances of effectually treating the rupture which result from it, the operation should always be recommended. I do the operation before applying a truss, because the crying which occurs after it nearly always causes the hernia to come down in spite of the truss, and because the ointment dressing, which I apply, and which I find infinitely the most satisfactory in children, seriously damages the truss.

In cases in which I purpose to operate on the hernia I perform any necessary circumcision ten days or a fortnight beforehand.

In older children I think it is always advisable to sound the bladder for stone after completing a circumcision. I happened to detect a calculus quite unexpectedly in this way in a boy who was sent to me because a truss which he had worn for eighteen months did not control his hernia. I found he had a marked degree of phimosi and on circumcising him passed a sound as a routine practice, and was surprised to find a stone which had given rise to no symptoms, other than might have been accounted for, by a tight prepuce.

In all cases of hernia a careful examination of the scrotum must be made to ascertain whether the testicles are normally descended. This would appear self-evident, but my excuse for mentioning the point must be the fact that I have now seen several cases in which this deformity has been overlooked and trusses ordered, which either pressed directly on misplaced organ in the inguinal canal or displaced it upwards, preventing any possibility of its descent or closure of the funicular process. Where an undescended testicle complicates a hernia, truss treatment is, of course, out of the question; and an operation comprising a radical cure and transplantation of the testicle into the scrotum or replacement into the abdomen is our only resort.

We now come to the all-important question, the closure of the funicular process, upon which depends the actual cure of the hernia. Two methods are at our disposal—the obliteration by pressure—truss treatment, and the removal of the process by operation.

Considering the treatment by trusses, the first question of importance is how soon is it to be begun? I say emphatically the first day the rupture is noticed, however young the child, provided always there are not very severe gastro-intestinal symptoms or phimosi present. I am strongly of the opinion that the earlier the age at which truss treatment is started the better are the chances of permanent cure resulting. I consider that no infant is too young for the application of a truss, and I feel certain that every day which is lost in beginning treatment increases materially the length of that treatment and diminishes the chances of a complete cure.

Having decided upon the application of a truss the question arises as to what type is most satisfactory. My experience is that a light steel truss covered with indiarubber is much the best. It is essential that the truss should be made specially for each individual case. I think the most satisfactory plan is for the instrument maker to see and measure the case for himself, and that when the truss is ready the doctor should apply it and judge of its merits.

The points of importance with regard to these trusses are—that they should be covered with some impervious material, that the spring should not be too strong, that it should not press on the anterior superior spine of the ilium, that the pad should not be larger than necessary, that it be flat, not conical, that it should not press on

the spine or the pubis and lastly, that the truss should keep its position and retain the hernia without the aid of a perineal band.

Dealing with the method of application of these rubber covered spring trusses which I have found most satisfactory, it is advisable not to apply them next to the skin. A strip of plain lint, well powdered, should be placed round the pelvis and the truss put on over it. If this precaution is omitted, sores readily form under the truss, necessitating temporary cessation of treatment. In putting on or taking off the truss care must be taken not to stretch the spring more than necessary; carelessness in this direction will soon render a satisfactory truss useless.

In the management of the truss two points have to be impressed on the mother or nurse—first, that the truss must be taken off, the lint renewed, and the truss reapplied every time the child gets wet; and, secondly, that should the rupture come down under the truss then the truss must be immediately taken off, the rupture put back, and the truss reapplied. Should the first point be neglected excoriation rapidly occurs, which may necessitate the discarding of the truss for a time. Serious damage to the bowel may follow a neglect to attend to the second of these instructions. The child must be bathed with the truss on, after the bath the truss is taken off, the lint changed, and the truss reapplied. The truss must be worn day and night.

Careful management and constant attention are thus obviously demanded of those who have the charge of infants and young children undergoing truss treatment. Failure results in many cases owing to the absence of this necessary supervision.

One point I always emphasize most strongly, namely, that every time the rupture is allowed to come down it does away with all previous progress towards cure, that the treatment has to be started *de novo*. This impresses the necessity for constant care in the management of the truss and gives due warning of the penalty which has to be paid for its neglect.

In a considerable proportion of cases the truss treatment of hernia fails, either because the truss has to be discarded from time to time, or because it fails to keep up the rupture. The most frequent causes demanding the removal of the truss are sores which arise from the following conditions—the wearing of the truss next to the skin, the neglect to change the lint under the truss as soon as it is wetted, pressure of the spring on the anterior superior spines of the ilia, pressure of the pad on the pubic spines, excessive pressure of the pad over the inguinal canal, owing to too strong a spring; and the wearing of a truss which the child has outgrown.

The causes of failure on the part of the truss to retain the hernia are—a badly-fitting instrument, a conical shaped pad which by its pressure tends to open up rather than to close the inguinal canal and lastly, and of great importance, the persistence of one or more of the exciting causes of hernia previously enumerated. It is useless to continually order new trusses with stronger springs and larger pads in the endeavour to keep up a hernia which makes a frequent appearance, owing to some removable cause increasing the intra-abdominal pressure.

Let us suppose, then, that we have a case supplied with a well-fitting truss, that no exciting cause, tending towards the return of the hernia is present, and that the rupture is never seen again after the application of the truss; the question which faces us now is—How long must that truss be worn? This is a difficult question to answer. My experience leads me to think that a truss applied during the first three months of life, and retaining the hernia perfectly throughout treatment, should be worn or at least a year. In children from one to five years old a gradually increasing period of treatment must be recommended, I would say from two to five years. As soon as a child begins to run about there is greater difficulty in keeping the truss in position, and disappointments are frequent owing to the appearance of hernia which have perhaps not been seen for months, necessitating a new start of the treat-

ment. Even supposing the hernia to be completely and continuously controlled, the older the child is when the rupture appears the less tendency to repair there is present, and a consequently longer course of treatment is demanded. Over the age of six years I should certainly never recommend the adoption of truss treatment, because after that time I think we can only look upon it as a palliative measure. If a truss is adopted it must be worn for a length of time which will extend over school and university days, exposing the boy to risk of the return of the rupture when playing games, or debarring him from taking part in them. It will prevent his entering the public services, while in the humbler walks of life heavy work will have begun before a cure can be expected, and the risks of then discarding the truss will be correspondingly increased. As the structures at the external and internal abdominal rings become stronger the risk of strangulation of a hernia coming down under a truss is much greater, and the difficulty of retaining the rupture while playing games or doing hard manual work materially increases the chances of this accident occurring. I have met with two such cases of strangulation—one of which ended fatally.

I have frequently been asked—Is there any risk of the rupture coming back after the truss has been given up? Is the cure going to be permanent? I am afraid that we cannot definitely promise that it will be. I believe the majority of infants who are ruptured in the early months of life and who wear a truss for a year are never troubled with a return of the hernia. At the same time this success is not always obtained. I quote four examples:—

I. Ruptured at nine weeks. Truss applied, worn for fifteen months. Hernia came down three months after giving up truss.

II. Ruptured at nine months. Truss for sixteen months. Hernia came nine months after giving up truss.

III. Ruptured at three months. Truss for one year. Hernia came down soon after truss left off.

IV. Ruptured at eleven months. Truss for three years. Hernia come down one year after truss given up.

In children who are over a year old when treatment is started, the prognosis as regards cure by trusses must be more guarded, and the older the child gets the more difficult is it to obtain a permanent cure by this means. In this connection there is one point which I should like to touch upon, and that is—what proportion of cases of so-called acquired hernia in adults occur in individuals who have been ruptured in infancy and childhood, and have been treated and apparently cured by trusses? I think that if we could obtain some statistics on this question it would materially help us in assessing the true value of truss treatment. It is difficult to realise how pressure, such as that which a truss exerts upon the inguinal canal, can produce complete closure of the funicular process right up to the internal abdominal ring. I feel that in many cases a dimpling of the peritoneum, considerably more extensive than the normal, may remain in this position, and may predispose to rupture in later life. I believe that the treatment of hernia in children by trusses should be limited to cases occurring during the first year where no undescended testicle complicates the condition, and where the rupture is not very large. From time to time very large herniæ are seen during the first few months, in which one or two finger tips pass readily through the short inguinal canal into the abdominal cavity. Such cases I have found quite unamenable to truss treatment.

I consider that the parents should be warned that although cure is probable by this means it cannot be definitely promised. I indicate the time—a minimum of one year—during which treatment must be carried out, and emphasise the necessity for constant attention during this period without which no chance of success exists. I also think it advisable to explain that a frequent renewal of trusses will be necessary, a point of some importance in dealing with hospital patients on

account of the expense involved. As regards the length of time which a truss usually lasts before the patient outgrows it, I find three months with single, and two months with double, trusses to be about the average.

In all cases of hernia in children over one year I believe that operative treatment is infinitely the most satisfactory; and this I propose dealing with (by permission of the Editor of the M. P. & C.) next week.

RECOGNITION AND TREATMENT OF MENTAL DISORDERS IN PRIVATE PRACTICE. (a)

By W. H. B. STODDART, M.D., M.R.C.P.
Assistant Physician, Bethlem Royal Hospital.

IN his paper the author referred to the steady increase of insanity since the year 1859, when one person in 536 was certified to be insane, whereas in 1904 one in 288 was the proportion. He remarked that early cases of insanity were frequently overlooked by the general practitioner, and even by so-called nerve-specialists, on account of there being too great a wealth of euphemisms for insanity, such as hysteria, anorexia nervosa, neurasthenia, "nerves," and even "liver." He had no objection to these terms provided it did not lead to erroneous treatment, but he was sure that the diagnosis was too often made in all seriousness when the patient was really suffering from insanity. The most fertile source of error is when the diagnosis of insanity never occurs to a practitioner, whose main object is the detection and treatment of physical disease only. He advised the practitioner to allow the possibility of the existence of mental disorder to cross his mind more frequently.

Hypochondriasis is one of the greatest snares, in which the mental disorder is more often than not overlooked.

Loss of memory should be looked upon more seriously than it generally is, as it is often the first symptom of general paralysis, threatening dissolution of life.

The author considered that most cases of insanity were best treated in a special institution for the purpose. Travel, as a means of cure in acute mental disorder, he condemned absolutely, as being the worst form of treatment. Dements and chronic quiet delusional cases may be treated with benefit at the private houses of doctors, as they give but little trouble. The question as to what cases may be treated at home is important to the general practitioner. When the mental disorder forms part of the general break-up of an aged person, an effort should be made to treat the disease at home. Obsessional insanity should also be treated at home as the every-day occupation in such cases is the best relief from the trouble. Other mental disorders that may be well treated at home are those of short duration, such as delirium of fever, or infection, *acute* intoxications, *some* acute epileptic states, and *some* of the exhaustion psychoses. Acute delirious mania can sometimes be treated at home. In such cases it is important to obtain nurses who have had plenty of asylum experience.

Insomnia being one of the most troublesome symptoms, it is often necessary to resort to hypnotics, if the usual measures have been tried without effect. Bromide with hyoscyamus is the best com-

bination for nocturnal restlessness, but sulphonal paraldehyde and amylene hydrate are the most successful drugs for the insane, the latter having the advantage of being a heart stimulant. When the usual hypnotics fail, it sometimes becomes necessary to resort to a general anæsthetic.

With reference to feeding: when the patient absolutely refuses food, it is necessary to feed by tube either nasally or orally, as it is a most important factor in the successful treatment of insanity that nourishment should be given.

Dr. Stoddart concluded his paper by enumerating the means of procedure in sending a patient to an institution.

THE ONSET OF FEAR AND THE ONSET OF PAIN IN CARDIAC DISTURBANCE. (a)

By GEO. R. WILSON, M.D., M.R.C.P.E.D.,
Medical Superintendent of Mavisbank Asylum Midlothian.

As illustrative cases of the subject dealt with, the author gave the following cases:—

(1) A widow lady, suffering from mitral incompetence, who was awakened suddenly in the night-time by a paroxysm of fear, which took the form of a dread that she was about to do harm to her mother. (2) A young girl, free from organic lesion of the heart, but with a weak, irregular circulation, who had exactly the same feelings of terror. It must be noted that these fears were not obsessions; they were of a paroxysmal character. (3) A merchant, whose activities were very multifarious, and who had cardiac enlargement but no murmur, complained of waking at night in a panic, which in his case always took the same form—that he had made a mistake in signing a cheque. (4) Alcohol and tobacco producing functional cardiac disorder often caused such fears, as shown by the cases of a man of 33, who woke up at night trembling and sweating with fear of delirium tremens, and another man whose terror was that he had committed some delinquency which was on the eve of discovery.

Some cases of night terrors in children were probably also of cardiac origin; he had seen a boy who, during an attack of this form of sleep disturbance, suffered from arrhythmia of the pulse. Probably the cardiac disturbance in these cases was secondary to digestive disorder. As to the nature of the cardiac derangement which produced paroxysmal fear, in only one of his cases was there any organic disease; the functional derangement was generally an irregularity and slowing of the pulse due to cardiac inhibition. Strictly comparable to paroxysmal fear were two other phenomena—nightmare, and a subjective sensation of sinking. The speaker then drew an analogy between paroxysmal fear and the paroxysmal pain which accompanied many forms of cardiac disease. He supposed that in the case of fear impulses passing directly to the cerebral cortex, whether their impulses were of such a nature as to produce vascular disturbance there or otherwise, were misinterpreted and translated into fears, in exactly the same way as incoming stimuli were mis-referred and translated into pains in the arm, leg, testicle, &c. Some pains of cardiac disease were

(a) Abstract of Paper read before the West London Medico-Chirurgical Society, June 2nd, 1905.

(a) Abstract of a Paper read before the Edinburgh Medico-Chirurgical Society, June 7th, 1905.

referred to the region of the heart, others were irrelevant, and referred to distant parts of the body unconnected with the heart. It was to the latter that paroxysmal fear was most strictly comparable.

The practical value of his investigation was that by explaining to patients that these attacks of fear were due to cardiac irregularity their distress of mind was greatly alleviated. He urged on medical men that they should pay more attention to the psychological symptoms of disease, and not leave these to alienists.

Transactions of Societies.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

MEETING HELD THURSDAY, JUNE 8TH, 1905.

JOHN TWEEDY, P.R.C.S., President, in the Chair.

MESSRS. R. W. DOYNE and SYDNEY STEPHENSON read a paper on—

CRIBRIFORM CHOROIDO-RETINITIS,

a rare form of fundus disease. They described three cases in adult patients of a peculiar clinical type of choroido-retinitis, characterised by large membranous sheets of white exudation, lying in the fundus beneath the retinal vessels, and showing few or many round or oval holes, through which the colour and marking of the underlying choroid could be recognised. In some instances the holes might be filled with pigment. There were grounds for thinking that the affection had resulted from acquired syphilis. The authors rejected the view that the condition of the fundus was the outcome of the metamorphoses of copious hæmorrhages.

Mr. LESLIE PATON read a paper on the course of OPTIC NEURITIS AND ITS SUBSIDENCE AFTER OPERATION

in cases of cerebral tumours, and in it he analysed a series of 105 cases which had occurred at the National Hospital during 1903 and 1904. After excluding cases in which there was no optic neuritis or which were not operated upon, or which died shortly afterwards, there were thirty left in which it was possible to examine more or less fully the eye condition. The cases fell into four groups as regards vision: (1) There were eight in which there was little or no impairment of vision; (2) in eleven cases the patients were blind, or almost blind, before the operation, and afterwards their vision recovered, in some up to normal acuteness; in group 3 there were those which were practically blind at the time of operation, and which regained no vision (six cases); and also those in which the vision failed markedly in spite of the operation (two cases), giving a total of eight cases out of thirty operated upon who did not save the sight; (4) there were three cases in which one eye retained good vision, while the other became blind, or nearly so. A notable symptom in these cases was an attack of transient dimness of vision, which occurred most frequently in the cerebellar cases, and was probably dependent upon interference with the vascular supply of the occipital lobes.

In different cases the optic neuritis showed different appearances and the cerebellar cases showed more swelling of the disc than those in which the tumour was in the frontal and parietal lobes, while macular changes appeared only in a small number of cases, and even when these were present they were not necessarily associated with any interference of vision; this is in favour of the changes being superficial. The intra-dural tension was in all cases high. The swelling of the disc subsided gradually, but more rapidly in the cystic cases, while in those which led to blindness the disc assumed a papery-white appearance with arteries much diminished in size. In other cases where the sight was retained the disc had usually a muddy, greyish-pink appearance, but this disappeared,

and in some cases it was impossible to tell from the appearance of the disc that there had ever been optic neuritis; this was so in one of the cases in which there had been extensive macular changes, but the vision recovered to 6-6.

Mr. L. WERNER (Dublin) described the case of a boy, æt. 18, the sight of whose right eye had been failing for nine months before being seen, and black spots were lately observed to be forming on the iris. The iris was covered with coal-black spots of pigment, less marked above, and in addition there was a small brown tumour wedged into the angle of the anterior chamber at the outer side. The A.C. was deep, although the tension was raised; there was a deep glaucoma cup, and the vision was "hand movement only." The eye was enucleated, and the patient remained in good health one and a half years after the operation. The tumour was a spindle-cell melanotic sarcoma which affected the ciliary body, and the neighbouring parts were infiltrated with pigment cells which extended into the canal of Schlemm. The surface of the angle was lined with black cells and a large number of detached pigmented cells were deposited free at the bottom of the anterior chamber. The case was a typical example of a ring sarcoma, of which about seven cases have previously been recorded.

Mr. CARET (Jerusalem) read a paper on the use of STRONG APPLICATIONS IN THE TREATMENT OF OPHTHALMIA.

He said that in Palestine, among the numerous practitioners, both qualified and unqualified, there were many methods employed in the treatment of ophthalmia, and among them were very strong solutions of nitrate of silver. One practitioner informed him that he applied it to the eyes in solution of 20 per cent., and he himself had seen a prescription in which 60 grains to the ounce was ordered. These excessively strong solutions are productive of a great deal of injury to the eyelids and conjunctiva, and so damage the tissues as to cause necrosis, and thus development rather than death of any organisms that may survive or be subsequently introduced. It precludes the further use of this most useful drug, and he urged that it was never advisable to use a solution stronger than 20 grains to the ounce, and seldom should one go beyond 15 grains, or 3 per cent., while a 2 per cent. solution is the more useful strength for the majority of cases.

Dr. G. A. BERRY read a paper on VISUAL EFFICIENCY.

He considered that indemnification to sight after injury was in many respects unsatisfactory to both parties; there being no recognised scale, according to which compensation can be calculated. He pointed out that it was impossible, having regard to the different value of good eyesight to different individuals, to formulate an invariable scale of efficiency. One that possessed some elasticity in different conditions should be formulated. He proposed such a scale. The first thing to determine was the degree of vision in one eye alone, which just corresponded, for any particular employment to a complete loss of efficiency. The second was the average loss of vision in one eye alone, the other having full vision. The total efficiency, taking the vision of both eyes into account, was then discussed as a particular function of the separate efficiencies of each eye.

ROYAL ACADEMY OF MEDICINE, IRELAND. SECTION OF OBSTETRICS.

THE MEETING HELD FRIDAY, MAY 26TH, 1905.

President, A. J. SMITH, M.B., F.R.C.S.I., in the Chair.

SPECIMENS.

THE PRESIDENT (Dr. A. J. Smith), showed an ovarian cyst which illustrated grave complications.

Dr. E. H. TWEEDY asked Dr. Smith what method he adopted to separate the intestinal adhesions from the tumour, and what method he adopted to prevent the injured intestines from again becoming glued together?

Sir A. V. MACAN thought the suturing of the hole in the bladder an interesting point.

Dr. SMITH, in replying, said that as to the method of separating the adhesions, part of the specimen showed a portion of the cyst wall which was taken away where it had to be split down. As to the prevention of adhesions, there was a large area of intestine stripped of peritoneum, and he had to put in a number of very fine purse-string sutures in parts which appeared dangerous; the omentum, which was very long, was also used to cover them. He found that the single purse-string suture closed up the large hole in the bladder very completely on inverting the edges.

Dr. E. HASTINGS TWEEDY showed a ruptured uterus.

Sir A. V. MACAN said that personally he criticised "shock" very severely. It might occur, but his interpretation of it was sepsis. It did not depend on mere tearing of the lower uterine segment even with opening the peritoneum, else why was it not caused in operating. The woman was a long time in labour, and the rupture took place some time before admission, so he did not find much difficulty in regard to causation of infection. He remembered a case in the Rotunda of the "rubbing through" variety. There was an anterior displacement, pendulous abdomen, and the head went through into the peritoneum. The patient was a long time in labour, and the rupture must have taken place a long time before she showed symptoms of shock. There must have been a subsequent infection. As to the treatment if the child could be taken out *per vias naturales*, of course that should be done. If you could stop the hæmorrhage, and the case was not septic, it seemed unnecessary to open the abdomen. If the child had escaped into the abdominal cavity it seemed more rational to open the abdomen, and stitch up the rupture, or remove the uterus.

Dr. R. D. PUREFOY said that, personally, he found no difficulty in explaining the causation of shock, apart from the supposition of sepsis. In many recorded cases death occurred a short time after the rupture, and shock must have played a large part in bringing about a fatal issue. The fact of the child being in the peritoneal cavity would account for a good deal of shocks. He could not follow Dr. Tweedy's explanation of how these ruptures occurred, and thought that the old theory of the stretching of the lower uterine segment by the active upper segment was sufficient.

Dr. JELLETT thought it was not possible to say definitely that there was no such thing as shock. He went on to relate some experiments performed on animals by Crile in America, which went on to show that death might result from (a) heart failure when death could be averted by cardiac stimulants; (b) those in which the peripheral arterial resistance had entirely disappeared, due to vasomotor paralysis.

Dr. Smith said there was a good deal in what Sir Arthur Macan had said as to the non-causation of shock by operations which involved opening the abdomen, &c. He thought that septic trouble was largely at the bottom of these cases.

REPORT OF THE ROTUNDA HOSPITAL.

Dr. E. HASTINGS TWEEDY, Master of the Rotunda Hospital, having presented his annual report of that important institution, a discussion took place thereon. The "Clinical Report" will be found in another column.

Dr. JELLETT said he had to congratulate Dr. Tweedy on his first report. He saw that a certain proportion of deaths had occurred in excess of what would probably occur in future years, but most of them were due to causes which were outside the control of the Master. He would specially like to congratulate him on the steps which he had taken to prevent the recurrence of sepsis, as he had introduced many important reforms, such as rubber gloves, finger stalls, separate utensils for each patient, &c. Going on to criticise the report *seriatim*, he referred to the fatal case of accidental hæmorrhage, and asked Dr. Tweedy how it was that because the membranes ruptured while the plug was being removed he did bi-polar version? Had the adoption of this treatment any relation to the theory of compression of the uterine artery which Dr. Tweedy brought forward to explain the action of the vaginal

tampon in accidental hæmorrhage? Personally, he did not think that the circulation in the uterine artery could be impeded by a vaginal tampon, nor did he think the application of a bullet forceps and pulling down the cervix could exert any pressure on the uterine artery. He considered that Dr. Tweedy's theory that you could bring down the angle of the uterine artery within reach of a plug was fantastic; since, when a vaginal tampon was put in, and a binder applied outside, the uterus was compressed between the two and did not change its position. Did Dr. Tweedy still hold to his theory?

Sir A. V. MACAN congratulated Dr. Tweedy on his report. He noted the enormous increase there was in the number of cases, and this was very striking. An interesting point also was the efforts made to combat sepsis. Personally he would think the important thing would be first to make a thorough investigation as to where the fault lay. He agreed with Dr. Jellett as to the value of the improvements. He did not consider rubber gloves of such great importance, and could not regard the stoppage of sepsis as being due to those measures. Rubber gloves were the fashion, but he himself did not consider them at all essential. As to the use of antiseptic dressings, he did not think their outward application to the vulva could be very important in parturition; if it were, the matter had been very insufficiently provided for by Nature. He thought there should be free drainage for the lochia. As to the maternity mortality, he still regarded the first case as having died from accidental hæmorrhage; and if plugging took so long to apply that a woman could collapse we should at once go back to Cæsarean section. It failed in its object if it could not be applied quickly, and you could leave it, and say it had stopped the hæmorrhage. He quite agreed with Dr. Tweedy about the abandonment of curettage, and thought it was quite time to give it up. He, like Dr. Tweedy, had been disappointed in the antisteptococcal serum, and to be of any use it would have to be a mixed one. Crede's ointment might turn out to be of use. With regard to the treatment of eclampsia, the simpler the treatment was the better, and if we agreed with regard to the injection of large doses of morphia, why wash out the stomach also?

Dr. R. D. PUREFOY said he would like to congratulate Dr. Tweedy on his clearness in enunciating his opinions, and his courage in defending them. With regard to some of the new measures, he might say that during his Mastership separate utensils were in use, and sterilised dressings for the vulva had been prepared and were partly in use. He was still a believer in the use of the flushing curette in suitable cases. He believed that the curette, when used in time, removed most of the organisms, and the patient was then able to resist the small dose which reached her circulation, therefore he was not prepared to give up the flushing curette. The Master urged against the curette that in the two cases in which it was used it failed. That was possible; it sometimes might fail, but the risk in skilled hands was infinitesimal. He thought that the risks of the curette were infinitely magnified by his new method. He was glad to find the Master had not lost faith in constitutional treatment, but why did he recommend mercurial inunction? As to the use of serum, he also had come to the conclusion that it was perfectly useless. With regard to the treatment of eclampsia he thought the practice of passing fluid into the stomach a very valuable one.

Dr. SMYLY congratulated Dr. Tweedy on his most interesting and excellent report. He had made many changes, and he thought they were all improvements. Rubber gloves were of great use, and especially in handling anything that was septic. The using of sponge holders by the nurses when washing the vulva was also of importance. The statement that there were only three cases of mastitis out of over 1,800 deliveries was different from his experience in his own private practice, and he thought that it was caused in nearly all cases by the nurses, who frequently contaminated their hands when washing the patient, and

then infected the nipple, and mastitis was brought about.

Dr. HORNE referring to the question of mastitis, said that these cases occurred usually in the second or third week, and after the patient had left hospital, so that probably many returned to the extern department. He congratulated Dr. Tweedy on his report. It was interesting to see, that notwithstanding all the advances that had been made a certain proportion of cases did suffer from various forms of puerperal trouble.

Dr. SMITH was glad to see that rubber gloves were used, and thought them a great step in advance. On the question of reckoning morbidity, he thought there should be a uniform standard on the Continent and here, and he considered the German method a good one, and it should be adopted. He congratulated Dr. Tweedy on his very excellent report.

Dr. E. H. TWEEDY, after thanking the members present for their favourable reception of the report, replied to the various criticisms and suggestions and the meeting adjourned.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.
MEETING HELD JUNE 7TH, 1905.

Professor CHIENE, C.B., President, in the Chair.

Mr. MILES showed four successive cases of acute generalised peritonitis treated by removal of the appendix and washing out the abdomen. (2) A patient, after removal of the spleen for traumatic rupture.

Mr. F. M. CAIRD showed a patient, admitted to hospital on account of head injury, in a semi-conscious condition. The drowsy mental state persisted for a week, and then twitching of the left side of the face, arm, and leg began. The skull was trephined over the right Rolandic region, and about four ounces of extradural clot removed. The dura expanded somewhat slowly, but the patient made a good recovery, consciousness being regained as soon as the effects of anaesthesia wore off. (2) A patient after removal of a gall-stone which caused intestinal obstruction.

Dr. NORMAN WALKER showed a case of "molluscum contagiosum," in which the growths were limited to the perianal skin. On account of the restricted distribution of the disease he proposed treating it with X-rays.

Dr. G. A. GIBSON showed a case of almost total ophthalmoplegia, external and internal, the only muscle spared being the left superior oblique. There was no optic atrophy. The patient experienced the sensation of constriction about the face, which is known by the name of "Hutchinson's mask." The tendon reflexes were abolished, the cutaneous reflexes increased, and the only other symptom was weakness of the right half of the tongue. The disease had begun five years ago by ptosis of the right eye. It was an example of so-called superior tabes dorsalis or preataxic tabes.

Mr. ALEXIS THOMSON showed a case of tropical abscess of the liver, treated by syphon drainage, after the method of Sir Patrick Manson. There were two conflicting schools of treatment in the disease; those who advocated free open incision and drainage, and the tropical surgeons who advocated syphon drainage, which had the advantage of being applicable under circumstances in which hospital treatment was unavailable. The case was quite a typical one, and was operated on by thrusting a large-sized trocar and cannula into the abscess, passing a red rubber catheter through the cannula to the bottom of the cavity, withdrawing the cannula, leaving the catheter *in situ*, and attaching a flexible tube, the end of which dipped into a jar of boric solution, to the catheter. This drainage had been allowed to go on for three weeks and the abscess had perfectly healed.

The following specimens were shown:—Vermiform appendices and excised spleen, by Mr. MILES; gall-stones and urinary calculi, by Mr. CAIRD; and a heart with both mitral and tricuspid stenosis, by Dr. GIBSON.

Dr. GEORGE R. WILSON read a paper on THE ONSET OF FEAR AND THE ONSET OF PAIN IN CARDIAC DISTURBANCE, an abstract of which will be found at page 641.

The paper was discussed by Dr. CLOUSTON, who said that it was in harmony with general experience that such fears should be nocturnal, since in the early morning the mental pain of disordered cerebration was most acutely felt, as in melancholia.

Dr. EDWIN BRAMWELL pointed out that the relation of mental symptoms to cardiac and other visceral lesions had been most scientifically and elaborately investigated by Dr. Henry Head, and that physicians could not be accused of having neglected this aspect of their work.

Dr. Macpherson, Dr. Ritchie, Dr. Graham Brown, and Dr. Gibson also discussed the paper.

Dr. ALEXANDER JAMES read notes on cases of ACUTE CEREBRO-SPINAL FEVER AND INTOXICATION, occurring recently in Edinburgh and in the surrounding district, clinically resembling cases of epidemic cerebro-spinal meningitis. He did not enter into any discussion of the nature of the condition or its mode of spread, but contented himself with giving clinical details of a series of cases with the object of attracting the attention of practitioners to the subject. Some of the cases had occurred a few years back, but the majority had come under observation during the past winter and spring. (1) A boy, while out in the country on a picnic, was found lying semi-comatose under a tree. In a few hours twitching of the limbs set in, and he died early next day. On *post-mortem* nothing except hyperaemia of the meninges was found. The next cases occurred in 1903, and consisted of one of nerve deafness, and one of blindness from optic atrophy which has resulted from acute illness, resembling cerebro-spinal meningitis. Then came a series of four cases during 1904-5; the first had an onset like pneumonia, followed by hemiplegic symptoms with petechial rash and opisthotonos. Lumbar puncture was practised, and the patient recovered, remaining, however, hemiplegic. The fluid withdrawn was sterile. Case two was a girl brought to the wards in a semi-unconscious state, complaining of headache and feverishness. Slight twitching of the hands took place, and lumbar puncture was performed. The fluid spurted out as if under pressure, and thereafter the patient was much relieved. Culture was negative. The third case was that of a girl complaining of headache and feverishness; difficulty in swallowing developed, and the patient died in four days. The fourth case was one beginning with signs of meningeal irritation, going on to left hemiplegia and head retraction. Lumbar puncture proved beneficial. No diplococci were found. Other cases of a similar nature were related, tending to show the present prevalence of cerebro-spinal infection in the neighbourhood of Edinburgh.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.
MEETING HELD FRIDAY, JUNE 2ND, 1905.

C. M. TUKE, Esq., M.R.C.S., President, in the Chair.

Dr. W. H. B. STODDART read a paper on the RECOGNITION AND TREATMENT OF MENTAL DISORDERS IN PRIVATE PRACTICE, an abstract of which will be found on page 650. In the discussion which followed the reading of the paper,

The PRESIDENT thanked Dr. Stoddart in the name of the Society for his interesting paper, and corroborated his remarks with reference to treatment, and he particularly impressed upon the members the imprudence of recommending travel in cases of acute mental disorder.

Dr. S. D. CLIPPINGDALE referred particularly to cases of anorexia nervosa occurring in private practice, in which cases it was difficult to carry out the nasal or oral feeding, and suggested rectal alimentation as being more suitable and better tolerated.

Dr. A. B. KINGSFORD questioned the advisability of administering hyoscine in cases of acute mania. He found that hyoscine given by the mouth appeared to be of great benefit, and giving quiet sleep, whereas given by hypodermic injection it caused an alarming degree of depression.

Dr. H. P. POTTER, in comparing the methods of feeding expressed his opinion that oral feeding carried out slowly and carefully was the most advantageous.

Dr. H. CAMPBELL POPE spoke of urethane as being a most valuable hypnotic in some cases. He also mentioned an important condition of the urine in so-called cases of neurasthenia, when, upon using Fehling's test, a dark discolouration is found, followed by a black precipitate—probably sulphide of copper.

Dr. W. H. B. STODDART made a few remarks in reply.

Special Articles.

POOR RELIEF IN SCOTLAND.

SOME time ago a number of the Superintendents of Poor were asked by the Local Government Board of Scotland to inquire into the methods of administering poor relief in Scotland, and to see if it were not possible to hinder the increasing number of applications for relief by the poor. They were asked to keep their investigations within the parishes of Edinburgh, Leith, Glasgow, Govan, Paisley, Dundee, and Aberdeen, as it was in these districts that the increase in poverty was greatest. These gentlemen submitted a number of recommendations and said that, in their opinion, poor relief was obtained with too great ease. They recommended that the Parish Councils should be divided into relief committees, a quorum consisting of not less than three councillors, and that one councillor should, if possible, be appointed chairman of all committees. Committees should meet once a week at least, when the inspector of poor should report the various applications for relief, and whether they should be accepted or not. The applicants should not themselves appear at the relief committee meetings, unless in exceptional cases, but these applicants, the Inspector of Poor, and the Parish Councillors, should be allowed the privilege of appealing against the decisions of the relief committees. The need of relief by the various applicants should be carefully looked into, the known "ins and outs" of course, being excepted. Cases should also be carefully inquired into at every application. The reports compiled by the assistant inspectors regarding applications, should, in all cases, be overlooked by the Inspector of Poor, or, if this be not possible always, by a chief assistant inspector. There should be a more thorough medical examination of applicants, and the medical officers should have better premises at the Parish Council offices and adequate assistance for the carrying out of examinations. Where it is possible the applicants should be examined by the same medical officer. The medical certificate should be altered to show if the applicant is physically "able to maintain" himself or not. If he is certified as being so, but is in poor health, a second medical certificate should be obtained before his case is refused. Refusals should be allowed to be given only by the Inspector of Poor previous to the time of meeting of the relief committee. Poor relief should not be given to applicants able to maintain themselves, so as to prevent an appeal to the sheriff. On an order being given for *interim* poor relief by a sheriff, the Inspector of Poor should see that his reasons for refusal are made known. The indoor poor should have stated on their medical certificates the probable length of their illness, and their case should be again examined into at the expiration of this period. The outdoor poor should be visited at least every month, and the rolls of both outdoor and indoor poor should be carefully considered every three months by the relief committee. The governors of the poorhouses should report to the medical officers any inmate who, in their estimation, is able to maintain him or herself. The Inspector of Poor should have power to discharge any inmates

on their being certified as able to maintain themselves. Lastly, the Commission thought that the establishment of labour colonies would be of great benefit in dealing with a certain class of applicants for poor relief. Outdoor alimnt should not be given when children are sent for it. Each parish council should draw up a scale of allowances, and when doing so should regard the expense of living in the parish.

GLASGOW ROYAL INFIRMARY RECONSTRUCTION.

DURING the last few weeks a number of letters have appeared in the *Glasgow Herald* on the subject of the rebuilding of this hospital, which, as is generally known, was first conceived as a memorial of the late Queen Victoria's Jubilee, and, as such, merely meant the reconstruction of the front portion of the hospital. The proposal was made in the first instance by Sir David Richmond, who was Lord Provost at the time. The scheme widened its scope, and plans were prepared by architects for the reconstruction of the entire hospital, with a considerably increased number of beds. An eminent Edinburgh architect was appointed to adjudicate on the various plans submitted by the different competing architects. His award was in favour of an architect whose plans were considered by many others well qualified to express an opinion on the matter as admirably adapted for their purpose. But, strange to say, the managers of the hospital, in the exercise of their wisdom, ignored the decision of the adjudicator whom they had appointed, and to whom they paid a handsome fee for services which apparently were not appreciated, and selected the drawings of a Glasgow architect whose plans had not even a second place by the award of the properly-appointed judge who was to guide the managers in selecting the best plans. This is briefly the history of what has given rise in many quarters to some unpleasantness. First of all, there was dissatisfaction expressed on the part of medical men, as well as the laity, at the proposal to rebuild a large hospital on the present site, many thinking that the existing hospital should be retained as a surgical one, and that a new hospital should be built elsewhere. Then, again, the Institute of Architects, and the Society of Antiquaries, through Dr. Murray, a well-known lawyer, have protested strongly against the great height of the contemplated hospital, as tending to dwarf the noble proportions of the ancient cathedral which is situated nearly opposite. A drawing of the hospital to be and the Cathedral appeared in the *Herald* recently, showing a very marked contrast between the two. Once more, the operative masons of Glasgow and suburban districts have just sent a strongly worded protest to the Board of Managers against their decision to build the outer walls of the hospital of terra-cotta, on the grounds that it is inferior to stone, and that it is unsightly and unstable compared with stone, especially red-stone. They further complain that it will deprive a great many workmen belonging to the city of employment which they naturally expect should fall to them. It has repeatedly been stated that building operations were to be commenced forthwith. It is surely a matter for regret that the managers have not taken the public into their confidence, when we recall the protests and complaints of various kinds which have frequently been made. The scheme for rebuilding has dragged on for a number of years, and it seems to us to be the bounden duty of the Committee in charge of the matter to indicate what has been done during these years, and what decision has been arrived at, in view, more especially, of the complaints placed before them from influential quarters, which cannot well be ignored, but which claim that a full and frank statement be forthcoming at an early date.

A STATUE to the memory of the famous seventeenth century physician, Sir Thomas Browne, author of the "Religio Medici," is in course of erection in the city of Norwich, where he was born.

France:

[FROM OUR OWN CORRESPONDENT.]

PARIS, June 18th, 1905.

TREATMENT OF OPHTHALMIA NEONATORUM.

PURULENT conjunctivitis in infants is due generally, as every one knows, to the penetration of the gonococcus into the conjunctival sac when the foetal head passes into the vaginal canal. Yet every purulent conjunctivitis, says Professor Terrien, is not necessarily due to blenorragia, for different microbes can provoke it, notably the pneumococcus; consequently account should be taken of this fact in forming a prognosis of the affection.

The method of Credé, however, consisting in instilling into the eyes of the child immediately it is born and before the cord is cut, a solution of nitrate of silver (1—200) has considerably diminished the frequency of purulent ophthalmia (from 10 per cent. to 0.60 per cent. on the average).

Where blenorragia is the cause, the inflammation sets in on the second or third day with considerable violence, but when a week passes before the first symptoms, the affection is due to pneumococcus, staphylococcus, streptococcus, &c., and is generally benign. This form of purulent ophthalmia is quite as frequently observed as the specific malady; the cornea is generally untouched, and the malady yields rapidly to treatment.

The treatment of the blenorragic form should be intensive at the outset—applications of cold compresses on the eyelids and frequent irrigations of the eyes with an ordinary douche at a distance of about a foot. The eyelids should be separated as much as possible. A solution of boric acid, protargol (1—100) formal, or permanganate of potash (1—5000) answers the purpose.

As soon as suppuration sets in the only treatment, according to M. Terrien, is that of cauterising the conjunctiva with a solution of nitrate of silver (1—2 or 3 per cent.). The solution should be instilled twice or three times a day and neutralised each time with a concentrated solution of salt. When the suppuration diminishes, protargol (10 per cent.) may be substituted for the nitrate of silver. When keratitis appears, the cold application should be replaced by warm compresses.

DIAGNOSIS OF TUMOURS OF THE PERINEUM.

By reason of the passage of the urethra through the perineum and of the strictures in the canal following blenorragia, the frequency of inflammation and tumours in this region is easily understood. In a classical point of view, says M. Cathelin, urinary abscesses and infiltration are the most frequently observed, but they might be confounded with a large number of other affections which can be found in this same region, and consequently it is necessary to distinguish them so as to avoid errors in diagnosis.

Urinary Abscess is the most frequently observed of all tumours found in the perineum. Its diagnosis is generally easy. The tumour is seated in the middle line of an average size, painful, inflamed, fluctuating. The history of the patient clears up the diagnosis.

Infiltration of Urine is a regular phlegmon representing a diffused form, spreading, according to the case, to the superior or inferior compartments of the perineum. In the former case the scrotum, prepuce, inguinal regions are the seat of inflamed and painful and œdema, while in the latter the signs of infiltration are observed around the rectum. The fever is high, and septicæmia sets in rapidly. Death follows if an operation is not done in time.

The *urinary tumour* generally communicates with the urethra. It becomes filled, when the urine passes at the moment of micturition, and the patient tells how he urinates a few drops after the want has been satisfied. Pressure on the tumour in emptying it into the urethra increases these drops. The tumour suppurates, leaving a fistula.

Bulbitis is a small tumour in the median line anterior

and superficial, more urethral than perineal. It is one of the forms of the urinary abscess.

Cowperitis can be acute or chronic, and is frequently found in patients who have had stricture. The tumour is lateral, and generally on the left of the raphe, mobile and painful to pressure. Later, in developing, it becomes fixed and causes lancinating pain. The tumefaction may invade all the perineum and when opened it is found to contain no urine, as in the case of urinary abscesses.

Abscess of the Prostate is easy to recognise by exploration of the rectum combined with palpation of the perineum. A very clear sensation of fluctuation can be thus felt between the two fingers. Besides, the prostate is found to be enlarged and painful, so that error is impossible.

Cold abscess of the perineum might have its origin in Cowper's gland or in the ischia.

Congenital cysts, lipomes, malignant tumours of Cowper's gland, syphilitic gumma, cancer of the prostate are rare, but have been mistaken for other affections.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, June 18th, 1905.

HEREDITY AND IMMUNITY.

AT the Wiesbaden Medical Congress, Hamburger raised the question of heredity of disease, and pointed to the recent advances of animal injections as anti-bactericides and antidotes against other diseases. This law, when carried further, points to the efficacy of a certain action of building up albumen in special cells which go to form the organism. Extending this logic still further, he divided cells into genera, species and individual characteristics. The generative cells possessing the specific albuminous formation were assimilated with an extra cellular body, which, by common nourishment in combination, formed a new organism participating more or less in the individual parental cells. From this he concluded that the tuberculously disposed cells were transmitted with very little variation from one generation to another. Chronic alcoholism may be induced in one generation and transmitted to the next by the same process of generation, which depends originally on injuring the parent cell by the excessive use of alcohol.

CONGENITAL THORAX PARALYTICUS.

Rothschild drew attention to a confusion of symptoms that sometimes arise in advanced conditions of consumption and thorax paralytica, both having an equally emaciated appearance in the region of the chest. The congenital form of the paralytic thorax is characterised by a narrow circumference of the chest, a shortage of development, a stunting of the sternum, a widening of the intercostal spaces, a lower position of the clavicle, and the alar appearance of the scapula. Thorax paralyticus usually precedes phthisis, and is an important factor in its development, probably owing to the loss of pulmonary expansion, crippling and contracting of the vesicular inflation with bending of the bronchus posteriorly at the apex, while the sternal joints become ossified and prevent expansion of the cardiac movement. The use of the spirometer, the sternogoniometer and passive movement with gymnastics, massage and faradisation, are all necessary in the early treatment of thorax paralyticus to check the advent of phthisis.

It is yet doubtful, but worthy of consideration, whether the ossified sternal joints should be surgically opened to allow free movement of the ribs.

COMPLEMENT OF BLOOD IN PULMONARY TUBERCULOSIS.

Kentzler gave the results of his examinations of blood in different stages of tuberculosis, and in all he found that the complement of the fluid was different at different stages of the disease when compared with the blood of a healthy person, but he was convinced that the protective quality was equally good in the phthisical

patient. He therefore concludes that the amboceptor is at fault or injured in the course of the tuberculous disease which allows the morbid germs to become superior.

PURULENT INFLAMMATION OF THE MIDDLE EAR.

Dudrewicz read an exhaustive paper on the complications arising from purulent inflammation of the middle ear. After criticising statistics and the different notions of ætiology, he declared that within the last two years he had met with 33 per cent. of such cases, of which 5.6 per cent. were acute and 27.3 were chronic. Periostitis is usually the result of mastoiditis, and should be opened to relieve the periosteal abscess at the earliest opportunity. When unable to remove the lamella of bone, he recommends trepanation. In the chronic form of the middle ear it is the tympanic side and the petrous bone which are usually affected, and may indirectly prove fatal by entering the cranium by the bony openings through which the blood vessels pass, and produce meningitis. The fatal causes associated with these forms of inflammation are purulent retention, formation of cholesteatoma, polypi, hyperostosis, sclerosis, caries, and necrosis of the petrous bone. In the chronic form pachymeningitis, extradural abscess, meningitis, serosa, cerebral abscess, thrombi, phlebitis, pyæmia, septicæmia, and fatal bleeding from the venous area and carotis interna. The exitus letalis is more frequently induced by aural discharges than is generally acknowledged, causing sudden deaths in typhoid, pyæmia, &c., under the name of apoplexy.

Bungary.

[FROM OUR OWN CORRESPONDENT.]

BUDAPEST, Ju 6 17th, 1905.

At the recent meeting of the Budapest Royal Medical Society, Dr. Temesvary read a paper on

TREATMENT OF VAGINISMUS BY ELECTRICITY.

Electricity, he remarked, especially faradism, gave good results. The secondary current from a coil with a long wire should be applied by means of an Apostoli bi-polar vaginal electrode. The electrode ought to be brought in contact successively with all parts of the vagina; and during part of the time should be firmly pressed against the pubis, where the cause of the spasm is most frequently situated. In all cases there were hyperæsthetic areas and caruncles, and upon these the current should be concentrated. The sittings should last for half an hour, and considerable patience must be exercised. In some instances benefit results from the first sitting, but more often from eight to ten sittings are necessary before improvement.

CARDIAC NEUROSES.

Dr. Hasenfeld, at the same meeting, referred to this subject. Functional disorders of the heart, he considered, should be classified as: (a) Nervous weakness, synonyms for which are neurasthenia cordis and irritable heart (reizbares Herz); (b) cardiac palpitation; (c) pseudo-angina, also called stenocardia and neuralgia of the cardiac plexus; and (d) abnormalities in rhythm: tachycardia, bradycardia, and arrhythmia. Each of these symptoms may be secondary to organic disease of the heart, or to some nervous disease generally functional. Frequently, however, any one of these symptoms may be the primary and sole disease. It is to such cases alone that the designation cardiac neurosis is properly applicable. Gerhart states that more than half the patients who consult him for cardiac trouble suffer from disorders of innervation, and have no valvular disease.

The diagnosis between functional and organic disease is usually easy. It may be difficult in cases of palpitation with hypertrophy of the heart, and in pseudo-angina and arterio-sclerosis. In cases of profound nervous prostration, in which cardiac symptoms predominate, it may be impossible to say which is primary and which is secondary. The following points are important:—(1) Neuroses are most frequent in young persons, in whom the usual causes of organic disease, such as rheumatism, are absent; (2) there is

often a family history of nervous disorders; (3) the pains and parasthesia in neuroses are generally diffused over the whole body, while in organic disease they are usually confined to the cardiac region, the left side and the left arm; (4) arrhythmia and other abnormalities in the pulse are less frequent in neuroses than in organic disease; (5) the absence of physical signs in neuroses even after long-continued cardiac neurasthenia the heart is not hypertrophied, and there is no accentuation of the second sound; (6) other organs do not suffer secondarily; (7) the symptoms of cardiac neuroses are often more alarming than those of organic disease. The neurotic patient, instead of instinctively avoiding exertion, like those with organic disease, more often cries out, and throws himself about.

The following typical case may be cited:—Patient, a woman, æt. 30, became depressed after giving birth to a dead child. Six months later she was suddenly seized with vertigo, palpitation, and the fear of impending death. The symptoms gradually disappeared with rest in bed, but the attacks reappeared after the least exertion. During an attack the pulse usually rose to 100, and the patient threw herself about on the couch. There were no abnormal physical signs, and the sphygmograms taken were perfectly normal. The pain did not radiate down the left arm. The urine was normal. Suggestion, ether, and nitro-glycerine gave no relief, and valerian but little. A five week course of baths and exercises at Nauheim had no effect on the cardiac symptoms, but recovery eventually followed at home.

Operating Theatres.

FRENCH HOSPITAL AND DISPENSARY.

REMARKS BY DR. LEONARD WILLIAMS on the case of Jacksonian Epilepsy reported in "Operating Theatres," June 7th, page 597, which is now practically recovered, and the patient expresses great subjective improvement as the result of the operation.

Dr. Leonard Williams, under whose care the patient was admitted, and who was unfortunately unable to append his notes to the first report, said that to the history given in the first instance it is necessary to add that the operation of 1903 was followed by most unfortunate results. A few days thereafter the wound suppurated, and the patient developed a complete right hemiplegia which was not, however, complicated by any form of aphasia. The suppuration resulted in a considerable loss of cerebral tissue. The only remains of the hemiplegia which were to be discerned at the time of his admission to the French Hospital were as follows:—There was some apparent over-action of the right face, considerable exaggeration of the deep reflexes and a persistent extension of the great toe. This extension of the great toe the patient explained always followed upon a fit. The toe would remain extended for several days and then gradually regain its normal position. It was very distinctly extended on his admission, and could with difficulty be brought into line with the other toes. The problem which seemed to present itself in considering the advisability of any further operation resolved itself into the question as to whether the seizures were due to the contraction of cicatricial matter in the brain itself, or whether the adhesions between the brain and the dura mater, which obviously existed, had any part in the causation.

Dr. Williams remarked that the case reported by Dr. Campbell Thomson in the *Clinical Journal*, which was operated upon by Mr. Kellock, seemed to render it probable that both these factors might be operative. The consideration, however, that it might be possible to relieve, at any rate a portion, of the irritation by freeing the adhesions, seemed to outweigh any disad-

vantages arising from the operation itself. In spite of his last very unpleasant experience, the patient was most anxious that something should be done.

When the matter was put to Mr. Owen, he agreed that although it would not be justifiable to attempt to excise any cicatrix in the brain tissue itself, it was more than justifiable to raise a flap of skin in order to free the parts from the irritation of useless adhesions. The adhesions having been found and removed, and, by means of the gold plate, steps having been taken to prevent any further irritation from this source, it is reasonable to hope that this will be the last operation to which this very plucky patient will have to be subjected. If the fits recur, we shall have reluctantly to decide that they are due to the contraction of the cicatricial matter in the brain itself, in which case no operative interference would avail for any appreciable length of time.

KING'S COLLEGE HOSPITAL.

ILEO-COLOSTOMY FOR MALIGNANT TUMOUR OF THE CÆCUM.—Mr. CARLESS operated on a woman, æt. 65, who was the subject of a growth in the right iliac fossa which had only been noticed for a few weeks. She had suffered from dyspeptic symptoms, pains in the legs and some increasing constipation for some weeks, but had not come under observation of a medical man till a few weeks before admission. A hard, nodular growth could be detected in the right iliac fossa which was slightly tender and movable; she had lost flesh and looked a little anæmic. No secondary nodules could be felt on examination under an anæsthetic, and the liver was not enlarged. The diagnosis was not a matter of doubt, but Mr. Carless pointed out that the possibility of radical treatment was more than doubtful owing to the very slight mobility of the mass. He said that if the patient were younger and had more vitality it was probably a case that might be treated by excision of the cæcum. He proposed to explore the abdomen, and in all probability would have to be satisfied by short-circuiting the growth. The abdomen was opened in the middle line, and a diagnosis of carcinoma of the cæcum was at once confirmed. The cæcum was found to be adherent to the posterior abdominal wall, and there was no evidence of secondary involvement of the glands or viscera. An ileo-colostomy was then performed. Lane's clamps were first applied to the ileum about two or four inches from the ileo-cæcal valve and the gut divided between them nearer the former. The cæcal end of the intestine was closed by a double row of catgut sutures, one dealing with the mucous membrane, and the other securing the sero-muscular coats. The mesentery was divided sufficiently to enable the upper end to be easily apposed to the transverse colon, into which it was implanted. The incision in the colon was made lengthways through one of the longitudinal muscular bands. No bobbin or button was employed, but the junction was secured by two rows of continuous sutures in the following manner:—The sero-muscular coat of one side of the ileum was first stitched to the colon, the sutures passing about one-eighth of an inch from the divided end of the ileum and a similar distance from the proposed site of the incision in the colon; the colon was then incised, and the exposed mucous membrane was united to that of the ileum by a second catgut suture which was introduced over and over continuously, securing the whole circumference of the artificial opening. The former sero-muscular suture was then carried on around the whole circumference of the artificial junction, the method known as Cushing's

right-angle suture being utilised. No additional sutures were required, and after the usual toilet the abdominal cavity was closed. Mr. Carless remarked that the opinion expressed before the operation had been fully borne out, and regretted that the patient's general condition prevented him from undertaking a radical operation, which would have been quite justifiable from the local condition of affairs. The operation would doubtless relieve the patient from some of the pain and discomfort associated with the ulceration and contraction which inevitably resulted from the development of a hard carcinoma of the intestine. He commented also on the gradual elimination of buttons and bobbins in intestinal surgery. The introduction of Murphy's button, he said, was a distinct advance, but when it was used the surgeon was always in a state of anxiety as to whether it would be regained *per vias naturales* or removed by the pathologist in the *post-mortem* room. Increasing acquaintance with the intestines had led surgeons to do without these dangerous and doubtful "helps"; any surgeon who had a pair of deft fingers and was at home in the abdomen could, he considered, make a satisfactory junction by means of needle and thread alone in a very little longer time than would be required for the introduction of a Murphy's button. The mucous membrane must be secured all round by a continuous suture not draw too tightly, and the sero-muscular coats should be united over it by a continuous or partly-continuous stitch, and for this purpose either the Lembert or the Halsted might be employed. Mr. Carless said he had latterly used Cushing's stitch with much satisfaction. This he pointed out in reality merely differed from a Lembert's stitch in that the needle was introduced parallel to the margin of the incision instead of at right angles to it.

The patient made an excellent recovery from the operation.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JUNE 21, 1905.

SUICIDE.

THE subject of suicide considered from the standpoint of scientific medicine, can hardly be otherwise than full of suggestive value. It is possible to conceive situations in which suicide

may be committed by a sane person. For instance, a Japanese officer who had failed to achieve some particular mission entrusted to his care put an end to his own life as the only thing left for him to do under such circumstances. Allowing a small margin of cases, however, there can be little doubt that the majority of cases of *felo de se* are brought about by some abnormal condition of brain. The fact that no changes are found in the brains of many suicides does not negative the theory of insanity. Not long ago the whole subject was dealt with by Dr. Wynn Westcott, the well-known coroner for the North-Eastern district of London, who has had an experience of suicide in all its forms extending over twenty years or more of official work. Speaking of the causes that lead to suicide he pointed out that it was not a question of cowardice or of bravery, or of the presence or absence of Christian principles. The most usual causes were disease, poverty, alcoholism, a fit of passion, or disappointed love. Then come two general observations that may well give pause to students of modern civilisation. First, the higher the standard of education the greater the number of suicides. That fact, if accepted barely as it stands, seems almost enough to make us despair of the future of society. A little further consideration, however, brings comfort in the reflection that our conception of higher standards of education may be wrong. Then, again, it does not necessarily follow that the association of the two circumstances stands in relation of cause and effect. The second general conclusion above referred to is that nations possessing the largest number of daily papers always produce the greatest number of suicides. If the relationship in this instance were causal the outlook for the United Kingdom would indeed be bad in these days of universal and multiplying journalism. Many of the facts in connection with suicide are of great interest, and most of them demand careful logical examination. Dr. Westcott states that Protestants are more prone to suicide than Roman Catholics, while the Greek Church comes next, and the Jews last on the list. It is extremely interesting to note that London has fewer suicides in proportion to population than any of the great capitals of the world. The rate in London is ninety per million per year, as against the alarmingly high figure of 400 suicides per million in Paris. It seems not unlikely that the last mentioned fact may have to be considered along with the rapid increase in the consumption of alcohol and in the decrease of the birth rate that have occurred in France during the present generation. The rate among soldiers and sailors is higher than among civilians, a fact which, by the way, is attributed to the enforcing of useless and exacting labour, such as excessive drill and attention to dress, upon our soldiers. Men commit suicide three times more often than women. The heaviest percentage occurs between forty and fifty years of age: after fifty-five the decline is rapid. Then we come to the important statement that child suicide is increasing. This lamentable

fact Dr. Westcott attributes to the strain of modern education. His interpretation is probably the correct one, as that appears to be the only altered factor of any great weight in the environment of modern child life. This point deserves most careful consideration by education authorities. It emphasises the contention of many medical men that school education should not be commenced at a tender age. The marriage state has a definite influence upon suicide and therefore presumably also upon society. Bachelors commit suicide more often than married men: married women more often than spinsters, widows more often than widowers: divorced men more often than divorced women. Lastly we come to the crowning statement that chronic alcoholism is the most general of all the causes of suicide. That fact, standing by itself, affords a damning indictment of the use of strong drink. Fortunately it is a preventable cause, and one that we may hope to see steadily increasing, as the habits and wisdom of the world steadily reach a higher standard. With the advance of medical science, also, we may confidently look forward to a lessening of the suicides due to incurable disease, a class that is answerable for the greatest number of suicides after alcohol.

MIDWIVES ACT ADMINISTRATION.

THE Midwives Act, 1902, has now been in operation for over a year, and the machinery for its administration is being slowly evolved. The more the Act itself is looked into, the more defective does it appear; the more the machinery is prepared the more gaps are visible. The House of Commons, in the plenitude of its wisdom, passed the Bill authorising the creation of an independent order of practitioners in the teeth of medical advice, and as if still further to demonstrate its own incompetence it allowed the Act to reach the Statute Book as full of inconsistencies and pitfalls as that egregious piece of legislation, the Workman's Compensation Act. Unlike the latter Act, the Midwives Act is not continually to come before the law courts for interpretation, but it is placed for administration in the hands of the Central Midwives Board, which consists neither of lawyers who understand the intentions of Parliament, nor solely of medical men who are acquainted with the needs of the community. It is, therefore, hardly a matter for wonder that the administration of the Act has become a patch work of ridiculous incongruities. Time and experience alone can decide whether the Act will ever be workable to such an extent as to attain even roughly the objects of its promoters, but it seems more than likely at present that an amending measure will have to be passed if the whole business is not to degenerate into a farce. At the present moment the Act and its administration are unsatisfactory to the last degree. The Central Midwives Board have drawn up a series of regulations for midwives registered with them, and the local supervising

authorities are supposed to see that these regulations are carried into effect. In forty-eight cases County Councils have decided to retain in their own hands the duties of local management, and the secretary of the Central Midwives Board publicly stated the other day that he wished all the administration were to devolve on the County Councils, and not to pass into the hands of District Councils. When it is considered that the County Councils meet at some central point, that their officers, being human, cannot be constantly present in the outlying districts, and moreover that many of the County Councils have not provided themselves with a medical officer of health, it is absurd to suppose that they can exercise anything but a nominal control over the hundreds of midwives practising in their respective areas. It is all very well for the Central Board to lay down a regulation that all midwives must wear washable dresses and aprons—doubtless a very desirable thing; but it passes the wit of man to conceive how the rule is to be enforced, if the midwife, as her own supervisor, receives a monthly, six-monthly, or yearly visit from an inspector. A midwife is bound to notify to the local supervising authority the occurrence in her practice of any case of puerperal fever. How midwives are to diagnose puerperal fever is an interesting conjecture, since many of them can neither read nor write, and some of them have no idea of the use of a thermometer. Puerperal fever is a notifiable disease already, but the notification is to be sent to the sanitary authority, and not to the County Council. If a medical man be called in, he will naturally notify to the local authority, and they doubtless will direct their medical officer of health to take steps to prevent the spread of infection. However, if the County Councils retain administrative powers under the Midwives Act in their own hands, and the midwife reports to them, they will not hear of a case of puerperal fever till long after the local authority has, and it is difficult to see what they can do even then, as they have no power, except over the midwife. An inspector, if they possess one, might be sent, but by the time of his, or her, arrival, all necessary steps would presumably have been already taken by the local medical officer of health. A sapient rule has been drawn up by the Central Board commanding a midwife who has been in attendance on a patient suffering from puerperal fever to disinfect herself and her appliances to the satisfaction of the local sanitary authority, and unless otherwise directed by the local supervising authority, to have her washable clothing boiled, and her other clothing "stoved" by the Local Sanitary Authority. Could a more elegant muddle of authorities be imagined? And how does the Board expect its illiterate *protégés* to understand what "authority" they are beholden to? The use of the word "stove" as a synonym for "disinfect" by a body concerned with the care of the public health is sufficient to show the deplorably inadequate scientific equipment with which the Board approaches its duties. Nothing perhaps better

illustrates the combinations of lofty ideals and eccentric peddling which characterises the action of the Board than the form of case-book which midwives are enjoined to keep, and produce when required. A column is devoted to the record of the "presentation" in each case. Does the Board seriously think that one per cent. of midwives are competent to diagnose a left occipito-anterior from a right occipito-anterior presentation? And again how many midwives does it expect to get reliable information from as to the duration of the first, second, and third stages of labour? Puerile as its action in these matters may seem, we regard some of its regulations as positively dangerous. For instance, a midwife is told to take to every confinement certain appliances. Among these are a catheter, an efficient antiseptic for disinfecting the hands, and an appliance for giving vaginal injections. So that, uncontrolled by any medical man, women of little or no education are to provide themselves with these lethal weapons and to start practising their use on the mothers of this country, under the ægis of a Board elected to protect poor women in their confinement. We leave it to our readers to contemplate the sort of results that are likely to ensue.

ANTHRAX.

THE increase in the average annual number of cases of anthrax during the past few years is a matter calling for serious attention from our public health authorities. In the decade ending in 1893, the average annual number of deaths from anthrax was only nine, whereas in the following decade it had increased to fourteen. At first sight one might suggest that the increase was apparent, not real, being due to more exact diagnosis and more careful registration. This explanation is rendered unlikely, however, by the fact that not merely are the absolute numbers of cases of the disease and of death therefrom increased, but there is a still more marked increase in the number of epizootic outbreaks. During the five years ending in 1893, the average annual number of outbreaks was 279, whereas in recent years it has risen to 640, and in the first quarter of the present year there were no less than 278. These figures make clear that the increase of the disease is not merely due to an increase of the importation of infected material for industrial purposes, but is due to a wide-spread infection of animals throughout the country. It is difficult to account for this wide distribution, since in the great majority of cases the source of infection cannot be traced. That the disease among animals has no relation to the presence of industries which might be a source of infection is shown by the geographical distribution. The counties which show the highest rates of epizootic anthrax are not those where industrial anthrax is found, and on the other hand, in many localities where industries associated with anthrax are situated, there is no occurrence of the epizootic disease. In Scotland, for instance, taken as a whole, anthrax

among animals is much more common than in England, whereas it rarely occurs in man as a result of industrial infection in the former country. It has been suggested that the spread of anthrax may be caused by the manuring of fields with infected material, but of this there is little proof. There is a gradual decrease in the total area of manured land, whereas there is an increase in anthrax. Professor Delepine has shown, however, from a study of reported outbreaks in Cheshire that the disease tends to recur with increasing frequency in limited areas. Nevertheless he does not believe that the carriage of infected manure or the importation of infected food-stuffs is a factor of great importance in the spread of the disease. It must be borne in mind, however, that the infection may persist for a considerable time on contaminated soil, and may be conveyed by grass, hay, grain, or other crop grown thereon. It is not believed that with sufficiently deep burial of carcasses there is great risk of infecting the soil, but it is well that cremation should, when practicable, be substituted for earth burial. It is unfortunate that at present the public health authorities have no efficient means of informing themselves of the presence of anthrax in an agricultural community. There is an obligation to notify cases occurring in a workshop or factory, but none with regard to cases occurring elsewhere. There seems to be no adequate reason why anthrax should not be one of the diseases notifiable under the Infectious Diseases Notification Act.

Notes on Current Topics.

Association of Nasal and Generative Changes

MANY observers have drawn attention to the occasional association of certain abnormal conditions of the nose and of the sexual organs. Less attention has, however, been directed to the physiological changes which the nose undergoes in connection with physiological changes of the sexual organs. According to Dr. Sinexon, of Philadelphia (a) there are certain definite parallelisms of this sort not to be explained by the use of any such term as "hysterical," or "neurotic." He suggests, for instance, that ancients and moderns alike have regarded the size and shape of the nose as symbolic of the degree of development of the generative organs. Whether this be so or not, there is no doubt that at puberty the nose undergoes certain definite changes. It is then that hair appears in the anterior nares, and that the erectile tissue on the middle and superior turbinate bones attains its high degree of vascularity and turgescence. Dr. Sinexon is not alone in noting that this vascularity is most marked during menstruation, and he draws attention to the fact that olfactory hyperæsthesia often occurs at the same period. Both in the lower animals and in the human race sexual excitement is accompanied by turgescence of the erectile

tissue of the nose, in some cases so marked as to cause occlusion of the nares and consequent mouth breathing. In some cases of prolonged sexual excess, this congestion is sufficient to cause a definite catarrh often accompanied with hæmorrhages. In cases where oophorectomy or hysterectomy has been performed, the nasal mucous membrane regains its infantile type. The whole subject of secondary sexual characters is from the biological point of view one of intense interest, and no opportunity should be lost of adding to our knowledge of it.

Heroin Habit.

ALTHOUGH heroin has not attained the general popularity that it once promised to, there are a number of practitioners who find it a useful and trustworthy agent in treatment. It has not only been used for its own qualities, but it has been suggested for use as a substitute for morphine in sufferers from narcomania. It may be well, therefore, to recognise that a heroin habit may be contracted, as noted by Dr. Charles E. Atwood in the *Medical Record* for June 3rd. Dr. Atwood's patient was a refined married woman, of neurotic tendency and nervous inheritance. She contracted the morphine habit herself at the age of nineteen, but was cured of it, and remained well for ten years. She was then operated on for appendicitis, and heroin was administered hypodermically to relieve pain which occurred subsequently. She found its effect to be pleasant and exhilarating, ascertained its name and being informed, according to her own statement, that it was harmless, began giving it to herself by subcutaneous injection. After a time she flagged in health; she lost weight, could not sleep, and suffered from digestive disturbances. When she came under Dr. Atwood's treatment the heroin was withdrawn, and diarrhœa and abdominal pain set in. She could not sleep, and at last a dose, one-twentieth of a grain, of heroin had to be administered. It was not needed again, however, and when the worst symptoms had passed off, the patient was sent to the country with a nurse for six months. She returned a happy and healthy woman. From Dr. Atwood's account it would seem that the heroin habit is at most as dangerous and undesirable as the morphine habit.

Motoring and the Treatment of Consumption.

THE pathogenic properties of the motor car have recently been abundantly demonstrated. Little, however, has been said as to its place in the treatment of disease. Long since THE MEDICAL PRESS AND CIRCULAR drew attention to the advantages which motoring might bring to the consumptive when conducted under carefully regulated conditions. We are glad to find that our recommendations are likely soon to bear fruit. An anonymous friend of the Mount Vernon Hospital for Consumption has offered to provide a suitably equipped motor-car for the use of the patients resident in the splendid new country branch at

(a) *Medical News*, May 6th, 1905.

Northwood. We understand that the donor desires this extension of open-air treatment to be tested in a thoroughly scientific manner. It is clear that it should be carried out only under skilful medical supervision. Dangers and difficulties may have to be met. Cases will have to be selected with care. The chauffeur should be absolutely reliable. Adequate attendance of course, must be supplied. The expense of maintenance must not be overlooked. And the freaks and frailties of suffering human nature may have to be circumvented. But, in spite of all objections we trust the experiment may be undertaken. The open-air treatment of consumption, although in no way a "specific cure," is nevertheless the best method known to present-day medical science for coping with a widely prevalent malady. For cases with persistent pyrexia, much muscular enfeeblement, cardio-vascular asthenia, night-sweats, anorexia, and other conditions contra-indicating exercise and necessarily tending to limit the application of hygienic measures, motoring when rationally conducted under medical supervision, may be expected, at least in many cases, to provide means for improvement and alleviation. For many advanced and pyrexial cases rest in bed is rigorously enforced in sanatoria, but evidence is not wanting to show that in certain cases such freer exposure to open-air as might be made possible by motoring may be peculiarly advantageous. The Mount Vernon Hospital was one of the first of our public institutions to demonstrate the effectiveness of the open-air treatment of the consumptive poor and we trust that the medical staff will see that this latest development of an up-to-date manner of providing the open air *in excelsis* for tuberculous workers will be thoroughly tested and carefully reported on.

Dr. Thomas Addis Emmet.

THE medical world of New York is having its share of junketing lately, for close on the farwell dinner to Professor Osler there has been a complimentary banquet to Dr. Thomas Emmet in celebration of his seventy-seventh birthday. Dr. Emmet may be regarded as the veteran among gynæcologists, and his services to that branch of surgery during the past half-century are not easy to estimate. It is, perhaps, somewhat the fashion at the present day to regard his methods and teaching as obsolete; but it is interesting to note in how many points modern practice is reverting to agreement with his views. In regard to methods of teaching he was as he put it himself, "a teacher, not a lecturer," wishing thus to emphasise the importance of clinical training as contrasted with systematic lectures. It is in great measure a result of his influence and example that medical teaching in America has adopted the method of the bedside rather than that of the lecture-room. Emmet, as a surgeon was one of the pioneers of aseptic methods long before their scientific basis in bacteriology had been discovered. At a time when

operative gynæcology was rash in its enterprise, he stood back as of the conservative school, and many procedures and modes of treatment condemned by him have long since passed into the limbo of forgetfulness. It is for such services as these that he is best known outside America, but by those who know him more intimately, he is equally respected as a teacher and honoured as a man. It is of interest to us to remember that he comes of a long line of medical ancestors, one of whom, the father of the ill-fated Robert Emmet—was a distinguished Dublin surgeon in the latter half of the eighteenth century. Many admirers in these countries will join with his own countrymen in wishing Emmet many years to enjoy the happiness and content that should follow a well-spent life.

More Dowie Riots.

IT is with regret we learn that the medical students of Edinburgh have lately resorted to riotous behaviour to show their disapproval of the methods of "Dr." Dowie and his followers. A Mr. Cautch, "the overseer of faith-healers," had engaged the Queen's Hall in that city to give a series of lectures on his methods, and on June 13th, he was to have addressed the meeting on "Medicine, Mother of Many Humbugs." The hall, however, was early besieged by a large body of students who objected to the science to which they were apprenticed being associated with such unsavoury epithets. Mr. Cautch perceived that discretion was the better part of valour, and he did not appear at the appointed hour to give his lecture. It would have been just as well, in fact better, if the students had been content with the success of their armed demonstration, but indignant at being robbed of their sport they stormed the hall, and proceeded to wreck windows, seats, lamps, and even the harmonium. Finally the police intervened and a fierce struggle took place, in which batons and bruised heads figured conspicuously. Several arrests were made. Making every excuse for the ardour of youthful spirits, and the degree of provocation presented, it is impossible to excuse such wanton excesses. Medicine is potent enough to assert her own position by the services she renders to sick people, however much she may be maligned by Faith-healers and men of their kidney. The ill-judged championship of students who make the insults of "Dr." Dowie's followers an excuse for horse-play and street fighting, detracts from the dignity without adding to the prestige of medical science.

The Composition of Nostrums.

THE ingenuity of the manufacturers of quack nostrums seems to be mainly exhausted in the concoction of advertisements, for the composition of the articles themselves shows a remarkable monotony. Thus, according to the report of Mr. Leach, the official analyst of Massachusetts, all the drink-cures which have come under his notice consist almost entirely of alcohol, and all the

diabetic foods of starch. In fact, in no point except that of price, do the nostrums warranted as cures differ from the substance they are intended to supplant. The advertisements of these cures are however, quite convincing. Thus, a liquid described as "purely vegetable, recommended for inebriates" contained alcohol in the proportion of 41.6 per cent.; a "non-intoxicating stimulant, whisky without its sting," had 28.2 per cent of alcohol; "sulphur bitters, contains no alcohol" actually contained 29.5 per cent.; but no sulphur; another liquid "entirely free from alcoholic stimulant" yielded 25.6 per cent., and "liquid beef tonic, recommended for treatment of alcoholic habit" contained 26.5 per cent. It is perhaps no wonder that such preparations are found satisfying by alcoholic patients. In the diabetic foods recommended as starch-free, Mr. Leach found that the proportion of starch actually present varied from 10 per cent. in the most innocent to 70 per cent. in others, and more than half of the preparations examined contained over 60 per cent. "Protein in its purest form" contained 59 per cent, of starch, so that one may wonder what protein in an impure form may contain. The price of these flours, however, was in some instances as high as two shillings a pound. As many of the preparations examined by Mr. Leach find their way into this country, it is well that medical men should be aware of their fraudulent and noxious character, that they may, where occasion offers, warn their patients and the public of the nature of the poisons offered to them under the guise of cures for this or that condition.

Trachoma in the Colonies.

It may encourage the weak-kneed amongst our legislators to know that persons suffering from trachoma are now being excluded, not only from the United States, but also from Canada, and that Australia and Cape Colony are preparing to take the same line. Last week Canada sent back a batch of sufferers from this undesirable complaint who had attempted to land on its shores, and they are now under the supervision of the medical officer of Glasgow. The subject of trachoma was brought before the Medical Council of the Cape at its meeting last month, in the form of a report and resolution by one of the members. According to the report it appears that on an average three sufferers are landed in the Colony every fortnight, and that the disease, which is quite foreign to South Africa, is now gaining a foothold in those places where the aliens congregate. Pure Kaffirs are fortunately immune, but among the whites no less than 139 per 1,000 of the patients at the new Somerset Hospital suffer from trachoma, whilst the districts of Oudtshoorn and Piquetberg are badly invaded. Dr. Wood, in moving his resolution that the matter should be brought to the notice of the Colonial Secretary, pointed out that as one country after another closed its doors to patients afflicted with trachoma, the stream of traffic concentrated itself towards those which

maintained the open door. Dr. Darley-Hartley, another member of the Council, expressed the opinion that there would not be much difficulty in getting an act passed when the matter was brought before the Government. The Colonies have much to be thankful for, when one reflects on the persistent long-drawn-out efforts that are necessary to get the simplest and most obviously necessary bill through the mother of Parliaments. It is much to be hoped that this session will see the Undesirable Aliens Bill placed on the Statute Book, as trachoma is assuming unwelcome proportions in this country.

Poisoning by Honey.

PROBABLY as long as honey has been used as a food, the occasional danger from poisoning by its means has also been known. At any rate we have an authentic account given by Xenophon, of poisoning by wild honey and from his time to the present the phenomenon has been well known. At the present day it not infrequently occurs in various countries, though it is curious how seldom the honey of garden bees has been blamed. It is probable that the poisonous substance in the honey is different in different regions, and consequently the symptoms cannot show any great uniformity. In some cases, for instance, gastric disturbances and in others cerebral predominate. In a series of cases occurring in New Zealand, and described by Dr. E. D. Aubin (a) both these sets of symptoms were observed, in some patients one set being most marked, in some the other, even when the honey eaten was the same. Speaking generally, however, it appears that the cerebral form of invasion is in New Zealand the most common, and the first sign may be a quite sudden epileptiform seizure. These seizures are repeated several times, and in severe cases the patient is unconscious and subject to convulsions during the interval. The exact nature of the poison has not, so far, been discovered, but it is probably an alkaloid gathered with the honey from certain plants, though it is likely that local opinion in different neighbourhoods is justified in placing the blame on different plants.

A Midwife's Operation.

THE unwisdom, to use no stronger word, of setting up under the protection of the State a class of practitioners for special purposes is illustrated by a tragic occurrence in Bradford. Any person connected with the practice of medicine knows the intimate association of all its branches, and how impossible it is to draw the line strictly between one department and another. To expect midwives to confine themselves to the practice of midwifery is to expect more of human nature than it is reasonably capable of bearing. In the case in question a mother had been attended by a midwife of "twenty years' experience," duly certified by the Central Midwives Board. On the

(a) *New Zealand Med. Journ.*, April 6th, 1905.

day following the confinement this authorised practitioner discovered that the child was "tongued," and she proceeded to perform the operation for the relief of the condition. She took a pair of scissors out of the bag, and—by way of disinfectant—wiped them with her fingers. Then she proceeded to cut the tongue and wipe the mouth out with rags soaked in water. The child's face and chin subsequently began to swell, and it finally died of convulsions and asphyxia. At the inquest the medical practitioner who gave evidence traced death to an ulcer in the mouth following a neglected cut. The jury accepted this view, but added that they did not consider that the neglect of the cut by the midwife was of a culpable or criminal character. Whatever may have been the midwife's responsibility, with regard to neglecting the cut, it seems to us that, if the facts were as reported, she incurred a far graver responsibility first of all by performing an operation, and secondly by performing one that was unnecessary. Charges of unlawful wounding have often been brought against people on less cogent evidence.

Rearing of Children.

AN interesting lecture was recently given by Professor Petrie, of University College, to the South Eastern Union of Scientific Societies at Reigate. In it he reviewed the factors in national existence that have been working to prolong and to raise the standards of life. Professor Petrie pointed out that through the operation of sanitary progress the death rate had been halved, and the average duration of life correspondingly increased. Unhealthy towns, he said, were wasting their capital as compared with the healthy towns, and it would pay Liverpool to tax the incomes of its inhabitants to the extent of half-a-crown in the pound in order to bring its mortality rate down to that of London. These conclusions, however, were somewhat eclipsed by the statement that half the energies of the nation were used up in the replacement of its own generation by the next. Looked at from one point of view the whole of the energies of a nation, except those which are devoted to the maintenance of the old and infirm, may be regarded as being directly or indirectly subservient to the production of a future generation, though incidentally a good many people manage to derive a good deal of entertainment for themselves in the process. But the point made by Professor Petrie in this connection that is worthy of consideration was that whereas this great mass of energy was employed in production, yet little or no attention was paid by the bulk of people to improving the quality of the article produced. He pointed out that the rearing and training of children were subjects in the regular school course in Canada, and that they were in fact as important to women as technical education to man. It is a good sign to see these matters being laid before lay audiences, for they vitally affect the credit and existence of the whole Empire.

Tonsils and Tubercle.

DURING the past few years our views as to the modes of infection by tubercle have been in a state of constant flux. The question is being fought out all over Europe, and America, and even in Japan, whether the common route of invasion is through the intestine, the lung, or the upper air passages. It is natural that under these circumstances the tonsil should have fallen under suspicion as a port of entry for the tubercle bacillus, and consequently it has been the subject of much investigation by observation and experiment. It is, of course, comparatively easy, by *post-mortem* findings, to establish the relative frequency of tuberculosis of the tonsil in connection with tuberculosis elsewhere, and a large number of observations of this sort has appeared in recent years. The relative percentage varies greatly with different observers, Dinichowsky placing it as high as 90, while Gourc made it out to be zero. From a large number of returns from various sources, however, it is safe to say that in not less than 70 per cent. of cases of pulmonary tuberculosis, the tonsils are affected. It is a matter of much greater difficulty to establish the occurrence of tuberculosis of the tonsil as a primary infection, since it is notoriously difficult to decide which of two or more lesions is primary. In many cases, however, tuberculosis of enlarged tonsils has been discovered on removal of the tonsils in patients in whom no sign of tuberculosis elsewhere could be discovered. Experiments on animals, too, show that it is quite easy to infect the tonsils by rubbing them with virulent cultures of tubercle bacilli. A series of experiments on pigs was recently carried out in this manner in the laboratory of the State Live-Stock Sanitary Board of Pennsylvania, and it was found that in such cases a certain reaction always occurred in the tonsils, but that much more marked change followed when the organisms reached the cervical glands. It is very probable that tuberculosis of the cervical glands may be due in many cases to bacilli entering through the tonsils, but up to the present there is little to suggest that the lungs are reached by the same channel.

Infantile Mortality.

THE diminishing birth-rate has given rise to considerable alarm in certain quarters, and it no doubt indicates a point deserving the careful attention of all who are interested in the welfare of the community. The fact remains, however, that a vast excess of human life is brought into the world merely to perish at a premature age. There is no greater standing reproach to the boasted progress of medical science than this vast and disproportionate infantile mortality that is the scourge of all civilised and semi-civilised countries. It may be said, indeed, that only quite recently has the matter been brought within the range of practical preventive medicine. The question is closely associated with that of physical deterioration,

which has lately been investigated by a Committee of the House of Commons. Degenerates may be regarded for the most part as the crippled survivors of the war which ignorance, want, and negligence wage incessantly against the infantile population. Some of the grosser evils were clearly indicated last week at the London Conference on the prevention of infantile mortality in the shape of the following resolutions:—(1) The instruction and care of mothers; (2) the early registration of births; (3) the appointment of women inspectors; (4) the importance of breast-feeding; and (5) the danger of premature weaning. A further resolution stated that in the case of those children who had to be hand-fed suitable milk should be provided in stoppered bottles accompanied by instructions as to the frequency and manner of feeding. The first great step in prevention clearly lies in educating the nation generally upon the question.

Dysentery in Bordeaux.

EVERY spring, according to M. Auché and Mdlle. Campana (a) the children of Bordeaux are visited by a serious outbreak of dysentery. The account these observers have published helps to make clear the distinction between bacillary dysentery, on the one hand, and amœbic dysentery and other varieties of dysentery on the other. It is so short a time since we were accustomed to regard dysentery as a single entity, that the clinical and pathological distinctions enumerated are peculiarly interesting. On the clinical side, the dysentery which prevails in Bordeaux is specially marked by its high degree of infectivity and by its acute course. In the latter point particularly it contrasts with the tendency to chronicity which is characteristic of amœbic dysentery. In the absence or extreme rarity of abscess of the liver the contrast is also shown. On the pathological side it is noticeable that the ulcerations are the result of a necrotic process extending from the mucous surface toward the deeper parts, whereas in amœbic dysentery the process starts in the submucous coat and only as it progresses is the mucous coat affected. The observers had no difficulty in deciding that Shiga's bacillus was the cause of the disease, as they succeeded in separating it in large quantities from the stools, and in obtaining a positive agglutination reaction.

Invisible Sputum.

THAT micro-organisms may be projected far and wide from the mouth of a speaker has been amply demonstrated by the recent experiments of Dr. Meryn Gordon. It is well known, also, that tubercle bacilli may be scattered along with saliva in the act of coughing or sneezing. The work of Dr. De Leon has tended to show that streptococci may likewise be spread through the agency of "invisible sputum." These organisms may frequently be found in the normal mouth without causing any morbid lesions, but it does not follow,

of course, that they would be harmless in suitable soil outside, as, for example, a freshly-made wound. Even if the buccal cavity were first well washed out with some antiseptic mouth-wash, but little diminution in the number of ejected organisms was observed. Dr. Alice Hamilton has been conducting similar researches at the Memorial Institute for Infectious Diseases, Chicago. A series of sterile Petri dishes was taken filled with rabbit's blood-agar, and these were systematically exposed before the mouths of fifty patients suffering from scarlet fever. Out of 34 patients who were able to cough or cry, 20 plates were found to have developed cultures of streptococci, and in 16 patients who were unable to do either, 13 plates showed typical cultures after exposure to simple expiration. It is therefore concluded that living streptococci are expelled into the air by scarlet fever patients, and these to a distance of 36 c.m. Seeing that these formidable germs can be communicated from one person to another in such a simple manner and that they are also found in healthy mouths, a new danger is thus created in surgical work. The practical outcome of these experiments would seem to lend support to the suggestion that has been already made, namely, that operating surgeons should take means to have their mouths protected during the actual performance of the operation. The "masked surgeon" will, doubtless, soon be a familiar figure in our operating theatres!

Food for Women Workers.

IF a systematic inquiry be made into the daily food in cases of anæmia and chlorosis occurring among the large class of young women and girls employed in factories and business houses, many astonishing replies might be received. Whether from motives of economy or from natural fancy, the mid-day meal of many of these women workers consists of a cup of tea and a bun or scone. This fare may or may not be consumed upon the business premises. If it is, the luxury of the short walk to the nearest eating-house is sacrificed to the somewhat spurious convenience of "not having to go outside." One brew of tea is, as often as not, made for all the hands employed in a certain room, and those unfortunate ones who are not in the first batch stand an uncommonly good chance of imbibing all the tannin when their turn comes. Some of the girls themselves soon get to know, from books or popular lectures, the evil effects of this beverage thus prepared, and prefer cocoa when that is supplied. A carbohydrate diet such as this, repeated on a smaller scale, perhaps, upon arrival home at night—for not every household can afford a meat-supper—soon plays havoc with the digestive system, not to mention the blood-forming organs. The country girl, accustomed to fresh milk and eggs, with her cheeks as ruddy as cottage garden roses, enters upon city life, and under new circum-

(a) *La Med. Mod.* May 24th, 1905.

stances of diet develops the peculiar pallor significant of a falling hæmoglobin percentage, and the well-known symptoms of anæmia soon assert themselves. It is gratifying, however, to note that the heads of many of our large business houses are fully aware of the importance of proper food for their employes, and we further note that most excellent dining-rooms have recently been opened in the West End of London, where women workers can obtain, at a very low figure, a meal that would satisfy the requirements of the strictest physiologist. Such a movement deserves to be widely imitated, and we have no doubt that it will be well supported.

A Boer View of London Medicine.

It is always interesting, often amusing and instructive, to see ourselves as others see us, and we confess that the London letter contributed to distant medical journals is often to an English reader the most interesting part of the paper. There is usually combined in such productions a freedom of criticism, albeit superficial, and a detachment of point of view which, if the personal element be not obtruded, may give rise to an indescribable piquancy. We find in a recent contribution to the *South African Medical Record*, from Dr. Rosenzweig, an intelligent comparison of the conditions of surgical practice and teaching in Berlin and London, as they appeal to the visitor. On the whole, he thinks that while the clinical material in London is of far greater variety, it is better exploited in Berlin. In the latter city as far as regards instruction, there is more attention paid to the details of diagnosis and treatment. He notes, too, that, in his opinion, at the time of his visit there was no adequate teaching at such an important hospital as St. Peter's Hospital for Stone in London, and he was frankly advised to go to Berlin to gain instruction in cystoscopy! Finsen and radium treatment Dr. Rosenzweig believes to have but a limited range in the treatment of lupus and malignant disease, and he notes their abandonment in many German clinics.

The Royal College of Surgeons, England.

THE last day for sending in nominations for the vacant posts on the Council of the Royal College of Surgeons, England, was Monday, June 12th, and we are informed that for the four vacancies there are six candidates. Two of these vacancies will in all probability be filled by the re-election of Mr. Edmund Owen and Mr. Rickman Godlee, so that for the two remaining vacancies four candidates will have to compete. These latter are in order of seniority, Mr. Andrew Clark, Mr. G. H. Golding Bird, Mr. W. Harrison Cripps, and Mr. W. Bruce Clarke. Thus it will be seen that no provincial Fellow is competing for a seat on the Council upon this occasion, all the candidates being well-known surgeons attached to Metropolitan Schools. We think it is a pity that

some provincial Fellow has not allowed himself to be nominated, for there are many prominent surgeons in the provinces to any one of whom the honour of election would be a simple recognition of well-merited professional status. The election will take place on July 6th next.

PERSONAL

MR. J. D. COBBOLD has generously offered to build an *annexe* to the Suffolk Convalescent Home at Felixstowe for the treatment of tuberculous children, at a cost of £2,000, and offers £50 annually towards maintenance.

VISCOUNT PORTMAN, being unable to perform the ceremony of opening the new out-patients' department of the Samaritan Free Hospital, Marylebone Road, sent a donation of £500.

BY the will of Mrs. Anne Maria Unite, of Blackwall Court, Bromsgrove, £20,000 has been bequeathed towards the rebuilding and equipment of the Birmingham and Midland Hospital for Women.

THE sum of £25,000 has again been offered to the London hospitals on the condition that a total of £100,000 is raised. This means that the hospitals can receive up to £125,000 towards the maintenance of their patients within a few weeks of Hospital Sunday, if £50,000 can be raised in addition to the £50,000 which is about the amount collected annually in places of worship in the last two years.

LAST week the new Middlesex Asylum, at Napsbury, which has cost half a million, was opened by Sir Francis Cory-Wright, Bart., D.L., chairman of the Visiting Committee.

THE prizes of the School of Pharmacy of the Pharmaceutical Society of Great Britain will be distributed by the President at the Society's house at 3 p.m. on Wednesday, June 28th.

SUBSCRIPTIONS to the amount of £3,077 were promised at the festival dinner of the National Hospital for the Paralysed and Epileptic over which Lord Strathcona presided.

THE address by Dr. Howard Kelly, of Baltimore, on the "Diagnosis and Treatment of Diseases of the Urinary Organs in Women," before the British Gynecological Society, on the 8th inst., attracted one of the largest assemblages known in the history of the Society, nearly a hundred Fellows and visitors being present. Dr. Kelly was previously entertained at dinner at the Café Monico by Dr. Macnaughton Jones, about fifty members being invited to meet the distinguished visitor. The address of Dr. Kelly will appear in full in our next issue.

DR. G. H. DAVIES, of Blackburn, one of the oldest medical practitioners in the town, has retired as honorary ophthalmic surgeon at the Blackburn and East Lancashire Infirmary, after twenty-one years service.

MAJOR E. C. F. GARRAWAY, Divisional Medical Officer of the Orange River Colony, becomes Principal Medical Officer of the South African Constabulary, in place of Lieut-Col. C. H. Burtchnell, who has resigned. Major E. L. Luther, Divisional Medical Officer of the Western Transvaal, succeeds Major Garraway in the Orange River Colony, and Captain F. R. Martin becomes Divisional Medical Officer of the Western Transvaal.

DR. J. P. TULLOCH has been appointed Medical Officer of the Chaguanas District of Trinidad.

DR. J. LEASK, Colonial Surgeon-Resident, Straits Settlements, is coming home on leave, during which Dr. R. Dane will take over the duties.

At the next meeting of the Senate of the University of Dublin it is proposed to confer the degree of M.D. *in honoris causa*, on Sir Richard Douglas-Powell, Bart., K.C.V.O., President of the Royal College of Physicians, London, and on Henry Rosborough Swanzy, M.B.; and the degree of Sc.D. on Edward A. Schafer, Professor of Physiology, Edinburgh, and on Sidney Young, Professor of Chemistry, Trinity College, Dublin.

DR. SHONE has been reappointed Lecturer on Physiology to the University of Cambridge; and Mr. G. H. F. Nuttall, Lecturer on Preventive Medicine and Bacteriology.

Correspondence.

THE SCOTTISH DIPLOMATES QUESTION.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—Most thoroughly do I agree with the address given on May 24th at the meeting of the "Association of Medical Diplomates of Scotland," and beg to thank you most cordially for your able and powerful article in the journal of the 14th instant on the subject, which is one of deep and paramount importance to those who, like myself, having obtained the "licence" of the Edinburgh College of Surgeons, have for a long time laboured under serious disabilities owing to the prejudice and incompetence of the general public to understand the question. I am the individual alluded to by Dr. Walsh as having been insulted by "a pert House Surgeon . . . who spoke of the Senior Surgeon of the Hospital, a man of ripe years and experience, from whom he had differed, as a mere Licentiate of his College," and you can understand that I feel deeply on the subject. On the occasion referred to by Dr. Walsh, I wrote (1897) to the Secretary of the Edinburgh College of Surgeons, asking him to give me *for publication* an exact statement of my locus standi in comparison with the membership of the English College. I need scarcely state that he told me (what I knew perfectly before) that my position was equal in point of law to that of M.R.C.S.England. Again in February, 1901, I wrote to him, pointing out the inconsistency of allowing, by the use of the word "Licentiate," the possibility of confusion in the minds of the general public. I passed my examination on March 19th, 1851, the day of reaching my twenty-first birthday. Although a London student, through some technical difficulty, which unfortunately culminated in my case, the privilege of allowing a man to go up for examination at the London College before the end of his third Annus medicus (which meant to me July, 1851) on production of proof of having attended the surgical practice of his hospital for the full twenty-seven months, by having utilized the holidays of April, August and September—for the latter two months of which I acted as Surgical Clinical Clerk—I was not allowed to offer for examination, and as the delay of four months in getting fully qualified was of great pecuniary importance to me, I petitioned the Edinburgh College, producing the necessary proofs, and was allowed to go up for examination, which then consisted of Surgery, Medicine, and Midwifery, so that, having passed the Apothecaries' Hall of London on March 27th following, I obtained an assistantship, doubly qualified in Medicine. Although I was never deprived of an appointment, yet my title of Licentiate often operated very unfavourably. I am too old to be affected by it now, but I am anxious to see the abnormality removed in the interests of my younger brethren, and consider that the College should take immediate steps to put them on a level with their English competitors. No more favourable time can possibly be found than this, the 400th year of the existence of the College. I have trespassed at some length on your space in order to show why I, as a student and prizeman of St. George's Hospital,

did not obtain the Membership of the English College of Surgeons and have ever since been handicapped by the designation of Licentiate instead of Member.

I am, Sir, yours truly,

JOHN EWENS,
L.R.C.S.Ed., L.R.C.P.Lond. (1861), and L.S.A.,
Consulting Surgeon to the Bristol Royal
Hospital for Women and Children.

Bristol, June 17th, 1905.

Obituary.

ARTHUR DAVID GRIFFITHS, M.D. BRUX., M.R.C.S.,
L.R.C.P.LOND.

A PATHETIC tragedy in connection with the typhoid epidemic at Bridgend, Glamorganshire, occurred in the death of Dr. Arthur Griffiths, who had been overburdened with work. He got up at half-past four, went into the bedroom where his wife was down with the fever, and told the nurse that he was very ill. Shortly afterwards he expired. A few hours before death he telephoned to his brother, Dr. John Griffiths, of Bristol, saying he was heavily overworked over the epidemic, and felt the strain very much. Dr. Griffiths graduated M.R.C.S. in 1894 and M.D. in 1897.

HUGH ROBERT HUGHES, M.R.C.S.ENG.

ANOTHER of the links with the olden days of Bangor was snapped by the death of Dr. Hugh Robert Hughes, Tanyfynwent, Bangor, who had been in failing health for some years, and died at the ripe age of eighty-eight. Dr. Hughes was the fourth son of the late Lieut. Hughes, R.N., of Plas yn Llangoed, Anglesey, and Dorothea Jones, his wife, of Llynon, Anglesey. He was a nephew of the late Sir William Hughes, of Plas Coch. He was educated in the Beaumaris Grammar School, and was registered as M.R.C.S.Eng. in the year 1839. Soon after that time he came to Bangor as house surgeon of the old Bangor Dispensary, which was then located at Tanycoed. After occupying the position for some time Dr. Hughes resigned and commenced to practise in the district, and gradually established an excellent practice among the better class, which he retained for many years.

HENRY COMERFORD, R.A.M.C., M.D.

WE regret to record the death of Colonel Henry Comerford, late of the Royal Army Medical Corps, aged sixty-one. He was appointed Assistant-Surgeon, March 31st, 1866; Surgeon, March 1st, 1873; Surgeon-Major, March 31st, 1873; Brigade-Surgeon, April 5th, 1892; and Surgeon-Colonel, July 6th, 1896. He retired from the service May 17th, 1902. He was present in the Zulu war in 1879, and was at the battle of Ulundi (medal with clasp); he was also in the Boer war in 1881, and took part in the defence of Pretoria, being mentioned in despatches.

WILLIAM OWEN WOLSELEY, R.A.M.C.,

L.R.C.P. & S.I.

THE Royal Army Medical Corps has sustained the loss of Colonel William Owen Wolseley, who died at Tilbury on the 3rd inst., aged fifty-one. He entered the Army Medical Service as Surgeon, March 6th, 1880; became Surgeon-Major, March 6th, 1892; Brigade-Surgeon, October 3rd, 1898; and Colonel, August 27th, 1903. In 1895 he served with the expedition to Ashanti, for which he was honourably mentioned, promoted to be Surgeon-Lieutenant-Colonel, and received a star. He was also with the Tirah Expeditionary Force in the campaign on the North-West Frontier of India in 1897-8.

THOMAS COLE WRIGHT, M.B., C.M.EDIN.

News has arrived of the death of Dr. Thomas Cole Wright, who had been practising at Gulgong, New South Wales, for some years. Although apparently in perfect health previously, he died suddenly from cerebral hæmorrhage. He once held the appointment of Honorary Surgeon to Dumfries Royal Infirmary, graduating M.B. in 1863.

Literature.

HANDBOOK OF SURGERY. (a)

THE author, in his introduction, mentions this book is intended to serve as a working guide for the student and general practitioner, and has attempted to present a brief outline of the principles and practice of surgery, giving as he states the essentials of the subject in as concise a manner as is consistent with clearness.

We have carefully perused this work, and our objection to it is that the many and varied subjects mentioned are too briefly treated, and the book would hardly satisfy the practitioner in this country when seeking information on a given surgical topic, or the student preparing for his examination, as his examiner would certainly require a fuller description than he will find in the pages of this work. However, much labour has evidently been expended on its preparation, and the book contains 417 very creditable illustrations. But like many American works of the kind, fulness and clearness of description have been sacrificed in many places for brevity. The book attempts too much and seems to have been brought out in too great a hurry, but probably in future editions the objections mentioned may be rectified.

LEGAL MEDICINE. (a)

THIS excellent manual may fairly be described as representing the high-water level of attainment reached by our trans-Atlantic *confreeres* in its very important and very interesting speciality. "The departments of toxicology and of the medico-legal relations of psychiatry have been purposely omitted from the volume, inasmuch as they have acquired an importance deserving, in each instance, independent treatment by specialists." We entirely agree with this opinion of the author. Those subjects can, in the present state of knowledge, be adequately treated only in separate manuals. He also tells us that the volume was meant "primarily, as a help to medical students interested in legal medicine, but it is adapted as well to the needs of practitioners who wish to have the latest advances in medical jurisprudence at their service." We feel, on closing the volume, that this view expresses a just claim—fully attained. We have perused the volume not only with a continuous impression of profitable mental instruction, but a correspondingly unbroken one of sensuous gratification. Paper, type, and illustration—we may add, binding—leave nothing to be desired. The author's manipulation of his subjects displays throughout the unconscious ease which characterise the dictation of a past-master of each and all of the topics on which he has undertaken to instruct the reader. The eye of the practised reviewer can at once recognise the personality behind the work exhibited, when the art displayed has reached a degree of culture which effectively screens its own presence from the eye of the ordinary observer.

Among the specially valuable portions of the text of this volume to which we would call attention are the chapters (IV. and V.) on "Sex and Doubtful Sex," and "Personal Identity." Those on "Impotence and Sterility," and "Rape" (to which three chapters are devoted) are of peculiar excellence, and display the keen practical sense of the American. For our own personal instruction—recollecting that the land of Benjamin Franklin (and his kite) is also the land of electrocution—we perused Chapter XXVI. (which discusses "Death by Electricity") with special interest. Here our trans-Atlantic contemporaries possess important first-hand data, which we must be contented to receive only through them. There are here given

(a) "A Handbook of Surgery for Students and Practitioners." By Frederic Richardson Griffith, M.D., Surgeon, Bellevue Dispensary; Assistant Surgeon at the New York Polyclinic School and Hospital, &c.; With 147 illustrations, Pp. 579. Philadelphia: W. B. Saunders and Co. 1904.

(b) "A Text-Book of Legal Medicine." By Frank W. Draper, A.M., M.D., Harv.; Professor of Legal Medicine in Harvard University, Royal 8vo., pp. 573. Illustrated. Philadelphia: W. B. Saunders and Co., 1905.

all the essential facts regarding the actual and potential powers of mischief connected with "live" wires, of which we have some experience at home. But we find also a skilled report of first-hand observations on electrocution, which still remains a scientific preserve, or perquisite, of our American cousin. Discussing the general subject of death from electrical shock, the writer proceeds to observe: "Rigor mortis has been believed to be an exceptionally early change, so early, indeed, and so transient, as to be regarded by some as not to have appeared at all. Autopsies on the bodies of men electrocuted revealed rigidity to be not radically unlike that ordinarily observed in time and degree."

For the perusal of all other items of the text of this manual, we cordially recommend the reader to the original volume. We feel sure that he, like ourselves, will not be disappointed.

THE MILK PROBLEM. (a)

THE objects of this little volume are to show the deplorable ignorance and wilful negligence displayed—almost to a criminal degree—by those on whom we have to rely for a supply of milk; then, to prove how those Acts and regulations at present in force, although undoubtedly lessening the dangers of impure milk, are very far from eliminating them, even in those cases where they are enforced with more or less activity; lastly, to suggest what means would be most likely to ameliorate the present state of affairs.

With these aims in view, the author presents to us in a most compact and convincing way excerpts from Royal Commissions and quotations from books and articles written by authorities on the subject. On first sight it appears impossible to crowd into a book of this size sufficient material to justify its title, but Dr. Lawson Dodd has proved his capability to deal with the subject—up to the hilt, and furthermore has shown that due sense of proportion in a remarkable way so that the book is pregnant with facts, figures, and opinions. Dr. Dodd first proceeds to show the necessity for the book, then he deals with existing evils, and shows how private and municipal enterprise has proved that the idea of a pure milk supply is not an impossible Utopian ideal, but a very practical one. It behoves every medical man who has not already studied the subject to have at his finger ends all the salient points of the evils of the present system, and we know of no better means of obtaining a reasonable conception of the subject than to peruse this efficient, accurate, and honestly written little volume.

LACK ON PHYSIOLOGY. (b)

ALTHOUGH the author of this volume states that it is not "intended to encourage cramming" we are unable to resist the impression that its contents, arranged as they are in succinct paragraphs and tabulated statements, could hardly be better adapted to this particular system of acquiring knowledge. The book is, in fact, a summary of our present knowledge of physiological science, a synopsis, rather than an "Introduction." The first twelve pages are devoted to a brief description of the more common histological methods and stains, many of the directions for which are far from complete. The reader is then conducted over the whole of the field of physiology, from the amœba to the development of the central nervous system. The chapters on muscle, nerve, and digestion are the best in the book, the recent experiments of Pawlow in relation to the nervous mechanism of secretion being briefly alluded to. Only five pages are devoted to the consideration of the blood, and no mention is made of the function of the leucocytes. A diagram of the blood-spectrum is relegated to the

(a) "The Problem of the Milk Supply." By Lawson Dodd, M.R.C.S., L.R.C.P., L.O.S. Eng., D.P.H. Lond. Pp. 76—iv. London: Baillière, Tindall and Cox. 1904. Price 1s. 6d. net.

(b) "An Introduction to Physiology." By L. A. Hodgkinson Lack, M.B., Ch.B. Edinburgh and London: William Green and Sons. 1905. Pp. 214.

appendix. In the section on the ductless glands the author states that in acromegaly the pituitary body is always diseased. As a matter of fact, a few cases have been recorded in which the hypophysis cerebri has shown after death no change at all, or only very slight hypertrophy. The last sixteen pages are occupied with outline directions for the practical chemical testing of the various fluids of the body. Students of physiology will certainly find this book of assistance in systematically reviewing their subject prior to an examination, and, as it is interleaved throughout, it will be useful for the class-room or for private study. An index might with advantage have been added. There are no illustrations.

TRANSACTIONS OF THE CLINICAL SOCIETY OF LONDON. (a)

THE Transactions of the London Clinical Society for the Session 1903-4 constitute a volume which well maintains the reputation that that Society possesses for its record of interesting and unusual clinical cases. The papers within it occupy about four-fifths of the entire book, while the brief notes on exhibited cases fill the remaining fifty pages. Among such a number of important scientific studies it is difficult to select any that are more specially worthy of mention than others, but one or two apparently deserve wide attention. Of this class is the report by Cuthbert Wallace and H. J. Marriage on a "Case of Attempted Division of the Eighth Nerve within the Skull for the Relief of Tinnitus." As far as we are aware, no previous attempt of this kind has been made, and consequently the paper opens up a new field of activity for the surgeon. Unfortunately the operation in the case reported was followed by a fatal result, but still we feel sure that it was quite justifiable. Many patients afflicted with tinnitus aurium and vertigo would be willing to accept permanent and complete deafness in its place, and not a few would be willing to risk death for the hope of relief. We therefore consider that this contribution is of great importance, and look forward to the record of similar and successful operations. Immediately preceding the above described paper in the volume is one on "Severe and Fatal Hæmaturia of Unknown Origin," by W. G. Spencer. We refer to it because of the great importance of such cases. Undoubtedly a form of anal and also bladder epistaxis exists, apart from the condition found in blood diseases, and the recognition of the fact should prevent hasty and useless operations, which have only too often been performed in such cases. Amongst the rarities described may be mentioned the case of "Myositis Fibrosa" of Dr. Batten, the cases of polypoid tumour of the heart by Drs. Thompson and Aitchison, and Dr. Goodall's paper on "Intestinal Obstruction following Enteric Fever."

On the whole we have said enough to show that the volume is well worthy of perusal in its entirety, and is of considerable scientific value. It is nicely bound, is well printed on good opaque paper, and is provided with an index.

THE EDINBURGH MEDICAL JOURNAL. (b)

It is unnecessary to deal at any length with this volume, as the individual numbers of which it is composed have been already referred to in our columns. Perhaps the most important communication that it contains is the series of papers by Sir Batty Tuke and Charles Howden on "The Relations of the Insanities to Criminal Responsibility and Civil Capacity." The four papers on this subject complete a series of nine, and inasmuch as the combined medical and legal knowledge of such authorities in the two professions as are the authors are brought to bear upon the matter, they form a most valuable and thoughtful con-

tribution. We hope that the papers will be put together and re-issued in book form.

The volume itself is very nicely got up, and representing as it does, the 100th year of the existence of the journal, must be a source of pride to the Edinburgh Medical School of to-day. Its value is enhanced by the inclusion at the end of notes on "Medical and Dental Education in the United Kingdom," and also of the regulations dealing with entrance into the Royal Army Medical Corps, and other public services. We notice, however, with regret that the index is sandwiched in between the above-mentioned addendas and the end of the medical part of the book. The fact may seem a small one, but is of considerable importance to anyone who wishes to look up the index of a large number of volumes. We hope that in future numbers the index will be found either at the beginning or end of the book.

SUPPLEMENT TO THE CALENDAR OF THE ROYAL UNIVERSITY OF IRELAND. (a)

WE have received the volume of Examination Papers set in the Royal University of Ireland during the year 1904, and which constitutes the Supplement to the Calendar for this year. In its general get-up it conforms to that type with which almost everyone is familiar, and will prove of undoubted value to students who are working for the examinations of that university. It may perhaps be especially recommended to medical students, who will find in it not only the actual papers that have been set, but also accounts of the practical tests that are set in chemistry, pathology, and similar laboratory subjects. It includes also this year the papers set for the Diploma in Teaching, and which should prove of much service in indicating the standard required from candidates in that examination.

Judging the general standard of the papers from those set in the various medical examinations, the knowledge required of students must be of a high order.

THE AFTER-TREATMENT OF SECTION CASES. (b)

SOME time ago we had the pleasure of reading and reviewing Dr. McKay's "History of Ancient Gynecology," when we learnt to know him as an interesting and learned writer. That book was to this as Theory is to Practice, but the same literary qualities are shown in this as in that, and the effect is to seize and hold our interest in the subject, and compel our admiration for the patient labour expended on it. The author takes a comprehensive view of the scope of "Preparation," including under this heading an account of the preparation not only of the "case," but also of the theatre, with its furniture, and the operator and his staff; and it will probably surprise not a few surgeons in this country who read this book to find how thoroughly abreast its author at the Antipodes is with the best operative procedures and after-treatment of cases. The subject of "Preparation" occupies about one-fourth of the book, and we can cordially recommend the perusal thereof to all young surgeons who are about to embark on their operative career, as well as to the experienced men who wish to see how far their mode of procedure corresponds with the latest ideas. The remainder of the book is concerned with "After-Treatment," and we find here everything that is known on the subject. Space would not allow of a detailed account of what the author has to say; but in this wealth of material we can specially recommend the sections on Shock, Hæmorrhage, Sepsis, and Intestinal Obstruction. Under each heading the author discusses Etiology,

(a) "Supplement to the Calendar of the Royal University of Ireland for the Year 1905." Dublin: Ponsonby and Gibbs.

(b) "The Preparation and After-Treatment of Section Cases." By W. J. Stewart McKay, M.B., M.Ch., B.Sc., Senior Surgeon to the Lewisham Hospital for Women and Children, Sydney, etc. 650 pp. London: Bailliere, Tindall and Cox. 1905. Price 15s. net.

(a) "Transactions of the Clinical Society of London." Volume XXXVII. London: Longmans, Green and Co. 1904.

(b) "The Edinburgh Medical Journal." Vol. XVI. Edinburgh and London: Young J. Pentland. 1905.

Symptoms, Prophylaxis, and Treatment. We have said enough to show that we can heartily recommend this book to all concerned in abdominal operations. The only adverse criticism that we have to make is that it is somewhat diffuse in places, and would readily stand condensation. No fewer than 32 charts of operation cases are shown, whose value, in our opinion, is not commensurate with the space they occupy. Nevertheless, we heartily congratulate Dr Stewart McKay on the all-round excellence of his work, and the publishers on its production.

SAINT BARTHOLOMEW'S HOSPITAL REPORTS. (a)

THE annual volume of the Saint Bartholomew's Hospital Reports is always welcome, and one has learned to look forward to its advent with confidence and with a certainty of deriving much interesting and useful information. We are glad to find that the volume before us has not disappointed us in this anticipation. Sir Dyce Duckworth's "Remarks on Some Diseases Which May Present Misleading or Seemingly Unimportant Symptoms" forms a fitting opening for the volume, and contains many interesting and instructive lessons. Dr. Norman Moore contributes an interesting note on two cases of pericarditis in enteric fever, both of which he regarded as a rare local manifestation of the development of Eberth's bacillus. There are also interesting papers on medical subjects by Dr. J. A. Ormerod, Dr. W. P. Herringham, Dr. W. L. Brown, Dr. G. C. Garratt, Dr. J. L. Maxwell, and Dr. S. L. O. Young. The surgical contributions are no less interesting than the medical. We should like to draw special attention to the interesting paper on "Tuberculosis of the Female Breast," by Mr. Sydney R. Scott. Details are given of some twenty-seven cases which Mr. Scott has either seen clinically or examined histologically. From these observations Mr. Scott describes a form of "Tuberculous Sclerosis," which he says is not at all uncommon, though not previously described. "Without histological examination this form of tuberculosis of the breast will almost certainly be mistaken for scirrhus carcinoma." The volume contains the usual statistical record of the cases treated in the Hospital during the year.

JOURNAL OF THE RÖNTGEN SOCIETY, NO. 2 VOL. I. DECEMBER, 1904.

THE Journal of the Röntgen Society is issued bi-monthly during the working session, at four shillings per number to non-members, and contains about 30 pages of clearly-printed matter, with our plates and several figures.

As the whole science of X-rays and Radio-activity, is more or less in its infancy, in spite of the amount of work that has been done in connection with it, there is still unlimited material for original investigation and need for new and improved apparatus. The account of such investigations and apparatus as have been brought before the Society will be found useful to those wishing to keep abreast of the times in X-ray work. The Journal also contains Notes and Abstracts from current literature. In the present number they deal with "Radio-activity of Ordinary Matter," "N-rays," "Y-rays of Radium," "An Automatic Potential Regulator," &c. The number before us contains the Presidential Address on "The Present Position of X-rays in Medicine and Surgery," by C. Thurston Holland, M.R.C.S., L.R.C.P. It is an interesting account of their uses, and the President points out that there is a good field for an X-ray expert; at the same time he strongly condemns their use for diagnostic and therapeutic purposes by those who are not qualified to practise medicine.

A paper on the "Perspective Nature of X-ray Projection," by William Cotton, M.D., lays stress on

the principles that should be used in interpreting X-ray photographs.

"Notes on a New Ultra-Violet Glass," by J. H. Gardiner, contains suggestions for its utility in radiotherapy, and is accompanied by a plate showing the transparency of various glasses to X-rays and luminous radiations.

This number also contains a short account of radiographs taken by a "pressure tube" apparatus, with photographs showing stone in the kidney, which in some cases could only be demonstrated when this method was employed.

Medical News.

Action of Cyllin on Pneumococcus, in Vitro.

DR. KLEIN reports:—Following up the experiments reported in the *Lancet*, April 15th, 1905, I have made observations also on the pneumococcus (*diplococcus pneumoniae*). This was derived from a recent case in hospital, and when used for the present experiment had been twice only transferred to culture medium. The medium used was nutrose ascites fluid and agar, a medium on which the microbe grows well and in characteristic fashion. From a twenty-four hours old sloped culture the condensation fluid, uniformly turbid with the organisms, was used to infect three plates (nutrose ascites agar) each plate receiving one drop, which was uniformly distributed over the surface of the set agar. One plate (No. 1) was retained for control, the other two plates being placed in a Bulloch's chamber and subjected to the "cyllin inhalant," which, by means of the "cyllin inhalator," was pumped into the chamber. One of these two plates (No. 2) was taken out after five minutes' pumping, the other plate (No. 3) was left in the chamber exposed to the remaining cyllinised air—but without further additional pumping—for one hour. At the end of this time this plate (No. 3) was taken out, and, with the other two, transferred to the incubator and kept at 37° C. for forty-eight hours. When the plates were removed from the incubator, No. 1 showed abundance of typical colonies of pneumococcus. No. 2 showed a fair number of such colonies, but much fewer than plate No. 1, and plate No. 3 was completely free of any growth. The same condition was noted after seventy-two hours incubation. From this it follows that by exposing the pneumococcus of recent and active culture for five minutes to the action of "cyllin inhalant," and keeping it exposed to the residual cyllinised air for a period of one hour in a closed chamber, this microbe becomes completely disinfected.

Durham University Medical Graduates Association.

THE annual meeting of this Association was held at the rooms of the Medical Society of London on Friday, June 9th, under the presidency of Dr. Hembrough, of Newcastle-on-Tyne, a good number of members were present. The annual report and balance-sheet of the treasurer showed that the numerical strength of the Association is steadily increasing and that its financial condition is highly satisfactory. The question of taking steps to obtain parliamentary representation for the University was again brought forward, and the result of the recent appeal made to the Senate on this subject discussed. In view of the advanced stage of the session, it was decided to postpone further action in the matter for the present. General regret was expressed at the retirement of Dr. T. Outterson Wood from the post of hon. secretary for the South, and a resolution acknowledging the excellent work he had done for some years in that capacity was unanimously passed. The following were elected as the officers and council for the year 1905-6:—President, Herbert T. Herring, M.B., B.S.; Vice-Presidents, Selby W. Plummer, M.D., and C. W. Chapman, M.D., M.R.C.P., Council, H. B. Angus, M.S., F.R.C.S., John Clay, M.B., F.R.C.S. H. Smith, M.D., William Martin, M.A., M.D., T. Beattie, M.D., M.R.C.P., E. W. Diver, M.D., John Capill, M.D., F.R.C.S.,

(a) "St. Bartholomew's Hospital Reports." Edited by A. E. Garrod, M.D., and W. McAdam Eccles, M.S., F.R.C.S. Vol. XL. London: Smith, Elder and Co. 1905.

F. H. Carter, M.D., F.R.C.S., F. E. Green, M.D., F.R.C.S., William Rawes, M.D., F.R.C.S., W. J. Hadley, M.D., F.R.C.P., Probyn Williams, M.D. Honorary Secretaries, J. W. Leech, M.D., F.R.C.S., for the North, and F. S. Palmer, M.D., M.R.C.P., for the South. Honorary Treasurer, R. A. Bolam, M.D., M.R.C.P. Auditors, C. S. Blair, M.D., F.R.C.S., T. M. Allison, M.D., and H. Smouthwaite, M.D. Watch Committee, W. C. Beasley, M.D., M. Mitchell Bird, M.D., M.R.C.P.; H. T. Herring, M.B., B.S., S. W. Plummer, M.D. The members and guests (numbering eighty-four) dined together the same evening at the Imperial Restaurant, Regent Street. Mr. Herbert T. Herring, the newly-elected President, occupied the chair. After the usual loyal toasts had been given, that of "The University of Durham and its Medical Graduates Association" was proposed by Mr. Christopher Heath, and responded to by Sir George Hare Philipson, and Dr. F. S. Palmer (honorary secretary for the South). The toast of "The Visitors" was proposed by Dr. Selby W. Plummer (of Durham), and replied to by Sir Lauder Brunton. Dr. George A. Heron proposed the health of the President, and Mr. Herring replied. Excellent music was provided under the direction of Mr. Arthur Godfrey, and a most enjoyable evening was spent by all present at the dinner.

Case of Plague at Manchester.

THE following statement has been issued by Local Government Board:—A case of plague has occurred at Manchester, the patient having been assistant cook on board a vessel which arrived at Middlesbrough on the 8th inst. The ship came from Buenos Ayres, via Hamburg, where she was reported all well on arrival. In consequence, however, of dead rats being discovered on board, measures were taken for destroying rats and disinfecting the ship. The patient's illness did not develop until the 9th, after he had left Middlesbrough, and it proved fatal on the 12th. All the required precautions have been taken both at Middlesbrough and Manchester for preventing extension of the disease.

University College Hospital Special Appeal.

THE Committee of this Institution have found it imperative to issue a special appeal for funds. Contributions from the public having been insufficient to meet requirements, it became necessary to sell out stock to produce £2,000 to pay pressing tradesmen's bills, and the committee find themselves placed in further difficulty owing to the new building having been handed over to them in an unfinished state by the Executors of the late Sir J. Blundell Maple, as the sum placed by him at the disposal of the Executors for the completion of the building had been exhausted, and they had no power to expend further money on it. The Committee are therefore compelled to provide a sum of about £3,200 for the execution of absolutely essential work, and they appeal most earnestly for donations to enable them to meet the cost of this work, and also for contributions, in the form of annual subscriptions and donations, for the maintenance of the hospital, so as to avoid further sales of stock and the consequent diminution of the permanent income of the Charity. In 1904, 2,744 in-patients and 58,321 out-patients and casualties were treated at the hospital. Contributions will be gratefully received, and may be forwarded to the bankers, Messrs. Coutts and Co., 440, Strand, W.C., or to the Secretary, Mr. Newton H. Nixon.

Queen's College, Belfast.

A MEETING of the subscribers to the Queen's College, Belfast, equipment fund was held in the council room of the College. The chairman, Sir Otto Jaffe announced that the sum of £30,000 had been collected, and said that he hoped the Government would now see their way to grant the additional funds required. Sir James Henderson moved that this meeting most earnestly desires to bring under the immediate notice of his Majesty's Government the strong and increasing claims of Queen's College, Belfast, to more generous treatment

by the State. The motion was carried. Sir William Whitla moved a vote of thanks to the contributors to the fund, amongst whom he specially mentioned the founders of the Musgrave Chair of Pathology and of the Riddell Demonstratorship, and Professor Redfern's gift of £500. A vote of thanks to Sir Otto Jaffe for presiding was then passed, and the meeting terminated.

Death under Chloroform.

IN the course of an inquest at East Hoathly on the body of a lad named Albert Hare, aged 13, who died from the effects of chloroform whilst undergoing an operation, the East Sussex Coroner remarked that deaths from chloroform were extremely rare, being no more than one in 10,000 cases.

Dr. Doyen's Disputed Fee.

DR. DOYEN, says the *Morning Advertiser*, the Paris surgeon, was summoned to perform an operation on Madame Fauconnier, of Ciergnon, in Belgium, in 1903. The fee asked by him was £1,200, which Madame Fauconnier considered excessive, and offered £160. This Dr. Doyen refused, and sued for the recovery of the amount claimed. The case was heard at Dinant, and went against the doctor, who, however, gave notice of appeal. The case came recently before the Court of Appeal at Liege, which confirmed the decision of the lower Court. Dr. Doyen is allowed £160, and has to pay the costs of both actions.

St. Mary's Hospital Medical School, Paddington.

Thursday, June 29th, is the date fixed for the annual distribution of prizes to the successful students of St. Mary's Hospital Medical School. The Right Hon. Sir John Gorst, K.C., has kindly promised to preside on this occasion. The ceremony will take place at 4 p.m.

University of Cambridge.

THE following list has been issued:—Doctors Designate in Medicine—E. W. Hedley, King's; W. S. Fox, W. Malden, and J. D. C. White, Trinity; and T. E. Holmes, Gonville and Caius. Bachelors Designate in Medicine—J. M. Hamill and J. C. Newman, Trinity; W. E. Paramore, John's; H. L. Wilson, Selwyn Hostel. Bachelors Designate in Surgery—Wilfrid Stephen Fox, John Molyneux Hamill, and John Campin Newman, Trinity; Charles Rowland Crowther and William Erasmus Paramore, John's; Thomas Jefferson Faulder, Clare.

THE following candidates have passed the necessary examinations during the meetings this term of the University Court:—M.D. Cantab., Wm. B. Knobel (Trinity College), Joseph Barnicot and Geo. S. Graham-Smith (Pembroke College). M.B. Cantab., John Goss (Jesus College). B.Ch. Cantab., Chas. E. Droop (Trinity College).

Trinity College, Dublin.

THE following candidates passed the final examination in medicine during Trinity Term, 1905:—Lily A. Baker, George MacG. Millar, Hercules J. and John A. Pringle, equal, Joseph W. Houston, Montgomery D. Ferguson and Thomas King-Edwards, equal, Alfred G. Alexander, Richard B. Bryan (Clk.), Madeleine S. Baker and William Nunan, equal, Henry A. Emerson, and John A. Sibthorpe, equal; and A. Cecil Boyd.

A NEW St. Petersburg Town Children's Hospital, built in honour of the coronation of their Imperial Majesties the Russian Emperor and Empress, has been opened recently. The hospital contains 400 beds, while the cost of the institution amounts to nearly £170,000.

THERE will be a conversazione at University College, London, on Wednesday evening, June 28th, and at King's College on Thursday, June 29th.

A COMMISSION has been appointed by the Paris Academy of Medicine to consider whether it is not advisable to prohibit the application of Röntgen rays by unqualified persons.

Notices to Correspondents, Short Letters, &c.

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

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 re-forwarding 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.

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.

J. WATSON.—Many who know the country say the descendants of exported Africans have seemingly lost their power of resistance to the malarial West Coast climate, the mortality among those repatriated in Sierra Leone and Liberia being excessive.

M.B. (London).—A foreign degree will also be necessary. You will find all you want in the *Index Medicus Hispanus*, published by the Colegio de Medicos, Gerona.

MOTORING (M.D.).—It is very difficult to make choice of a car, but certainly the ultimate expense is less. The chief requisites are comparative noiselessness, no excessive vibration, and plenty of knee room.

ALIENIST.—One reason for the establishment of colonies for the insane poor in France is the fact that for many years Paris has been deporting her share to provincial asylums to such an extent that in 1899 they numbered no fewer than 8,000. The largest colony is at Ainsy-le-Château, near Langrès.

DISTINCTION WITHOUT DIFFERENCE.

A RATHER humorous, albeit pathetic remark was uttered by a "casualty" patient the other day in the receiving room of one of our large East End hospitals. The man was brought in from a street accident with an injury to one of his legs, which, upon examination by the receiving room officer turned out to be a fracture. This being communicated to the patient he exclaimed: "Thank God, guvnor; ain't I glad it ain't broke."

DR. F. (Buxton).—The Blue Book on Cancer Research can be seen at any Medical Library or bought from Wyman & Son, Fetter Lane, London, E.C.

COLONIAL.—The address of the Medical Defence Union is 4 Trafalgar Square, London, and that of the Irish Medical Association, Royal College of Surgeons, Dublin.

M.B. Lond.—The pay is good in the Metropolitan Asylums, and the experience gained should be of exceptional service in your after career.

DR. F. (Kent).—Your suggestions commend themselves to our consideration, and we will see what can be done.

SURGEON, R.N.—The petechial rash of vomiting is often seen after sea-sickness, and has been known to cause intracranial frontal hemorrhage. It is also seen after attacks of whooping cough and epilepsy.

Meetings of the Societies, Lectures, &c.

WEDNESDAY JUNE 21st.

ROYAL MICROSCOPICAL SOCIETY (20 Hanover Square, W.).—8 p.m. Papers:—Mr. A. E. Conrady: Theories of Microscopical Vision.—Mr. E. M. Nelson: The Tubercle Bacillus.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. P. Paton: Clinique. (Surgical.) 5.15 p.m. Dr. A. P. Luff: The Diagnosis and Treatment of some of the Forms of so-called Rheumatism.

THURSDAY, JUNE 22nd.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Mr. D. Armour: Pain in Acute Abdominal Disease.

MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST (7 Fitzroy Square, W.).—5 p.m. Lecture: Dr. T. D. Lister: Pre-Tuberculous Affections in Early Life. (Post-Graduate Course.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Lecture: Dr. Gilles: Hemorrhage during Pregnancy.

FRIDAY, JUNE 23rd.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Dr. J. Horne: Clinique. (Throat.)

SATURDAY, JUNE 24th.

NEUROLOGICAL SOCIETY OF THE UNITED KINGDOM (National Hospital, Queen's Square).—10 a.m. Clinical Cases will be shown.

TUESDAY JUNE 27th.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—Lecture: Dr. A. E. Gilles: Puerperal Temperature.

Bacancies.

- St. Vincent's Hospital, Dublin.—Physician to the Extern Department, and Surgeon to the Extern Department. Applications for either vacancy to the Secretary. (See Advt.)
- Ashton Union.—Resident Assistant Medical Officer. Salary £120 together with furnished apartments, rations, and washing. Applications to John North, Clerk to the Guardians, Union Offices, Vauxhall Road, Birmingham.
- Borough of Weymouth and Melcombe Regis.—Urban District Council.—Medical Officer of Health. Salary £350 per annum. Applications to H. A. Huxtable, Town Clerk, Municipal Offices, Weymouth.
- Manchester Royal Infirmary.—Director of the Clinical Laboratory. Salary £200 per annum. Applications to W. L. Saunders, General Superintendent and Secretary, Manchester Royal Infirmary.
- Metropolitan Water Board.—Director of Water Examinations. Salary £1000 per annum. Applications to A. B. Pilling, Clerk of the Board, Savoy Court, Strand, W.C.
- The Victoria University of Manchester.—Junior Demonstrator in Anatomy. Salary £100 per annum. Applications to the Registrar.
- Ecclesall Bierlow Union.—Resident Medical Officer. Salary £130 per annum, with board, washing, and furnished apartments at the hospitals. Applications to Thomas Smith, Clerk to the Guardians, Union Offices, the Edge, Sheffield.
- Infirmary of the Wandsworth Union, St. John's Hill, near Clapham Junction.—Male Junior Assistant Medical Officer. Salary £100 per annum, with board, lodging, and washing. Applications to the Medical Superintendent.
- Borough of East Ham.—Medical Officer of Health for the Borough and Medical Superintendent of the Isolation Hospitals, Convalescent Home, and Schools. Salary (Medical Officer of Health) £300 per annum, Medical Superintendent of the Hospitals and Schools £100 per annum. Applications to C. E. Wilson, Town Clerk, Town Hall, East Ham, E.

Appointments.

- ATTWOOD, E. A., Assistant Secretary has been appointed Secretary to the London Homoeopathic Hospital.
- BRANDER, WILLIAM, M.B., Ch.B., Aberd., Resident Workhouse Medical Officer and Medical Officer for the Children's Homes Middlesbrough Union.
- COW, D. V., B.A., B.C. Cantab., Clinical Assistant to the Chelsea Hospital for Women.
- EARLE REGINALD ANDERSON, L.R.S.A. Lond., Medical Officer and Public Vaccinator for the Western-super-Mare District of the Ayrbridge Union.
- GIDLEY-MOORE, J. B. G., L.R.C.P. Lond., M.B.C.P. Edin., Certifying Surgeon under the Factory and Workshop Act of the Ongar District of the county of Essex.
- HASSARD, W., M.B. Dub., House Surgeon to the Weston-super-Mare Hospital.

Births.

- GREENE.—On June 9th, at Theatre Street, Norwich, the wife of Arthur Greene, M.A., M.D., of a son.
- LANGDON-DOWN.—On June 18th, at Dixland, Hampton Wick, the wife of Percival L. Langdon-Down, M.B., of a son.
- HATRICK.—On June 13th, at Welland House, New Barnet, the wife of Charles D. Hatrick, M.D., of a son.

Marriages.

- BARNICOT-BOTTOMLEY.—On June 15th, at St. Thomas's Church, Huddersfield, Joseph Barnicot, M.B., B.C., third son of the late John Barnicot, of Shepley, near Huddersfield, to Ethel Bottomley, eldest daughter of the late Joseph Bottomley, of Huddersfield.
- HOOPER-WOOTTON.—On June 15th, at St. Mildred's Church, Lee, Lionel Swinton Hooper, M.R.C.S., youngest son of J. Harwood Hooper, M.D., F.R.C.S., of Sidcup, to Ada Edith, elder daughter of Thomas Wootton, of Rotherfield, Burnt Ash Hill, Lee, Solicitor.

Deaths.

- DESIGN.—On June 11th, at 3 Park Terrace, Falmouth, the Rev. Henry Charles Design, M.D., late Vicar of East Teignmouth formerly Rector of Coulston, Wilts., in his 88th year.
- HUMPHRY.—On June 14th, at Grove Lodge, Cambridge, Mary, widow of Sir George Murray Humphry, M.D., F.R.C.S., in her 81st year.
- LUCEY.—On June 14th, Wm. Curit Lucey, M.D., of the Heights, Haslemere, Surrey, aged 64.
- MACKINDER.—On June 15th, at 12 Park View Villas, Hove, Fanny Anne, wife of Draper Mackinder, M.D., F.R.C.S., in her 74th year.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXX.

WEDNESDAY, JUNE 28, 1905.

No. 26.

Original Communications.

SOME SURGICAL NOTES ON TUBERCULOSIS OF THE KIDNEY. (a)

By HOWARD A. KELLY,
Professor of Gynecology in the Johns Hopkins University
at Baltimore.

As earnest thinking men you will all, I feel sure, at once agree with me that it is not so much the clever and the novel as the useful we should ever hold in highest esteem in our art. And especially in these days, I appeal to your judgment at a period in which we find ourselves literally engulfed in a chaos of new surgical procedures, evoked by the great discovery of your fellow townsman, Lister, do we not need as never before to investigate, to deliberate, to reject, and to accept?

The great keynote of this earliest decade of the twentieth century ought not to be something new, but the establishment of that which is good and the *unification of the surgery of the world*. I would far rather make all men recognise and do the well-known right thing than effect some large discovery and attract wonder and applause.

It is because of this strong conviction that I have not aspired this evening to the novel so much as the useful. May I venture also to suggest that I have come thus far hoping too, for a little of that collegial fellowship which was the notable mark of American and English intercourse throughout the latter half of the eighteenth and the first half of the nineteenth centuries, in the days of the two Hunters, of Smellie and the great Blundell, of Sir Astley Cooper and Sir Benjamin Brodie and a galaxy of departed braves whose mighty names still shine in your British firmament with ever-increasing lustre?

It was in 1871, as you will recall, that Simon extirpated the kidney, and then published that considerable work of his; and now about thirty-four years later the surgery of the kidney, as I grasp the subject, has pretty nigh reached its acme under the existing conditions of surgical science.

It is a pleasure in looking down the intervening years to recall the inestimable pioneer services of your own late lamented Knowsley Thornton, and then of David Newman, of Glasgow, and of Hurry Fenwick, all in this field, and I shall be happy indeed if my conclusions merit the approval of these veterans of the service. Although, as I have said, thirty-four years have elapsed since the field of aggressive renal surgery was opened up, in reality the operation for tuberculosis is still in its teens, for our surgeons were long held back from entering this beautiful field by a total misconception as to the pathology and clinical history of

the disease. Three serious errors blocked the path of progress:—In the first place, renal tuberculosis was seen by the pathologist only in cases of advanced or of general tuberculosis, so that the impression obtained that the disease was either a local expression of a general condition, or was almost invariably bilateral; in the second place the convenient and well-sounding, but unfortunate term "uro-genital tuberculosis" was long current, conveying the false impression that the disease of necessity involved more or less of the entire urogenital tract *ab initio*, and in the third place it was commonly assumed that the tuberculosis was of an ascending character, advancing from the bladder upwards, and therefore ineradicable. The true facts did not, as we shall see, warrant the clinician in making a general application of a single one of these *dicta*. Let me quote Rokitsansky (Lehrb. d. path. Anat. Wien, 1861, Bd. 3 p. 342): "Tuberculosis of the kidneys is but the partial expression of a primary tuberculosis of the urinary organs, and in the male commonly a part of a combined tuberculosis of the uro-genital system." Guyon, writing in 1888, declares "we do not know of a single case of renal tuberculosis, primitive and unilateral without lesions of the same kind in the bladder, the seminal apparatus or in other organs." I can but pause to note with Schede of Bonn, that Schmidtlein, writing as early as 1863, was the first to distinguish clearly between a urogenital tuberculosis arising in the male genital organs, and secondarily invading the bladder, the ureter, and lastly, the kidney, and a true primary renal tuberculosis which descends the ureter to invade the bladder from the opposite direction. Even as late as 1888 Steinthal (Virch. Archiv. Bd. 100) showed how hopelessly at variance were the current opinions touching this vital question.

As I consider the evolution of the history of our subject the following dates are important:—

1. The period of recognition of the disease, up to 1860.
2. The collection and sifting of a number of cases with both pathological and clinical histories in view, 1863–1885.
3. The stimulus to surgical thought given by Simon's first renal extirpation in 1871.
4. The discovery of exact methods of diagnosis, from 1876–1893.
5. A period in which the development of the surgical technique has been wrought out in the hands of a few specialists, 1890–1900.
6. The final period, the gradual transportation of the perfected operation into the hands of surgeons at large, may I say, from this present date on, 1905?

The nexus between etiology, diagnosis, and treatment is so closely woven that I must touch upon causation, if but briefly, in order to give my little sketch, taken, as it were, from a surgeon's diary, its due perspective.

In the first place, how does the disease reach so recondit an organ? Manifestly there are but three avenues of access:—By the blood, by ascending the ureter, by direct extension from some contiguous

(a) Read at meeting of British Gynecological Society, June 8th, 1905

organ. Baumgarten of Tübingen (1901), after some careful experimental inoculations of the urethra in rabbits, in which he succeeded in causing a tuberculous ulceration of the bladder, and the prostatic urethra, found himself utterly unable to provoke any like affection of the vasa or of the testicles on the one hand, or of the upper urinary tracts on the other. He therefore insisted that the tubercle bacilli, being no secretionsparasiten, never advance against the current of secretion, but always with it. This dictum, generally speaking, is true, although there are good clinical reasons for believing that in man the disease frequently extends from the epididymis to the bladder, where it may involve and cause a stricture of one or both urethral orifices, this in turn causes a slight hydro-ureter, and then follows the invasion of the upper urinary tract. A case of Albarran's, and one of my own, both with double kidneys, seem almost conclusive in this respect. An ascending disease in women is most rare, except when the disease has first affected one side, and then when this is in an advanced state of tuberculosis, proceeds to invade the bladder and the opposite urethral orifice in the manner depicted. I would call attention to the fact that I have never seen a primary ascending tuberculosis in upwards of fifty surgical cases, for the most part in women. I have seen several cases of vesical tuberculosis, primary or associated with a genital tuberculosis, but the kidneys were not involved.

I have also seen coincident renal and genital tuberculosis, but without other manifest lesion than the vascular system or some remote common depot of infection. I would therefore urge that what is commonly called uro-genital tuberculosis does not exist in women. Without any doubt the infection of the kidney is almost always hematogenous. It is important to note that the focus from which the blood becomes infected is often found in the thorax. Kel-nack (1897) in a series of autopsies studied with especial reference to tuberculosis of the kidney, found the lungs affected in 70 per cent. of the cases. The primary focus as has been shown by autopsy, is sometimes a cheesy bronchial gland apparently dormant, but for this accident. Let me urge with these facts before us that it is most important in every case to investigate most minutely the condition of the lungs. A study of this kind will sometimes serve to check a too sanguine prognosis.

Let me urge, too, in searching for evidences of latent disease, not to neglect overhauling such a fruitful field as the submaxillary, cervical, axillary, and inguinal regions for swellings or scars, as well as looking for old joint troubles.

The involvement by contiguity has been shown by Patoi (1897), who had a case of a girl of 19 with vertebral caries whose kidneys became involved by the extension of the disease through a mass of sclero-tuberculous tissue.

If for any reason the kidney becomes a *locus minoris resistentiæ*, it may then become affected by a tuberculosis when it would otherwise have escaped. This is proved (1) by cases of trauma (see especially Newman) followed by tuberculosis; (2) by the occurrence of tuberculosis with calculi, in a case of F. Heurotin's, of Chicago, the tubercular disease developed years after the abstraction of the stones; (3) by the occurrence of a tuberculosis grafted into a hydronephrosis, in instances too numerous and too entirely in accord with experimental data to be coincidental.

Before passing from this phase of the subject, I would ask my colleagues for further observations touching the asserted relationship between gonorrhœa and tuberculosis of the kidney.

A few words with reference to two vital points in the clinical history of this pseudo-malignant renal affection.

In the first place, tuberculosis once started, finds in the kidney so favourable a nidus that the disease becomes with perhaps the rarest exceptions, progressive. Time spent in trying to cure this disease by climatic or other methods is lost time, for the affection moves *pari passu* or *sallatim*, but in any case it

advances. Delay in active treatment means courting the risk of involvement of other organs.

The second is that a spontaneous cure is so rare an occurrence that Albarran could successfully challenge the French Surgical Society to produce an indubitable instance. A seeming cure is sometimes obtained with the complete caseation, destruction, and sequestration of the kidney, associated with the obliteration of the lumen of its ureter, but this natural cure (*sic*) is fraught with such risks of further dissemination, and is so protracted in its course that few surgeons I think would hazard it.

Excluding cases of general and miliary tuberculosis, rarely seen by the surgeon, and excluding those forms of the disease in which it is but a late complication of an advanced and manifest tuberculosis elsewhere, usually pulmonary, we have to deal with a disease which is local and unilateral in its onset, and which may remain local and unilateral for months and even for years. Given an affection of this character incompatible with health and in the end destructive of life located in a paired organ, one of which can readily be spared by the economy, what more fruitful field I demand, need the surgeon look for in which to exercise his precious skill?

The real crux of the situation is the diagnosis, and upon this capital point I would like to dwell a little.

DIAGNOSIS.

One is perhaps best able to realise the progress that has been made in the last decade and a half, in the diagnosis of tuberculosis of the kidney upon reading such a communication as Madelung's (*Centrabl. f. Chir.*, 1890. *Beilage*, p. 73), in which he declares that the demonstration of a renal tuberculosis is a matter of extreme difficulty, while catheterisation of the urethra is open to serious objection that in some instances in women it has given rise to incontinence. Madelung mentions the method of making an exploratory laparotomy in order to palpate both kidneys trans-peritoneally (Thornton), as a procedure not likely to lead to a definite conclusion, while a bilateral lumbar exploratory incision might be of value. He further declares that the inoculation of rabbits as an adjuvant to diagnosis consumes too much time, and if negative the result would of course be valueless. In conclusion, the unsatisfactory nature of the diagnostic measures at hand (in 1890!) forbid the surgeon to establish the rule of early operation in renal tuberculosis; on the contrary only those cases should be selected "in which the disease has progressed so far that a spontaneous recovery is impossible, and in which further after a prolonged observation there is the utmost assurance that the disease is limited to one side." I have thus quoted so excellent an observer somewhat in detail in order when contrasting our present status to heighten the appreciation of the remarkable advances which we have made within such a short term of years.

We have just seen that the clinical history of this almost malignant bacterial infection of so delicate an organ is characterised by the invariable tendency of the disease to proceed step by step until the kidney has been destroyed, and *pari passu* with its local progress is there a tendency to become disseminated, or to invade other vital organs? The careful clinical studies of the disease have further demonstrated the fact that the disease when it starts in the urinary tract, always attacks one kidney first, and then the ureter and then the bladder, and that the involvement of the other kidney is fortunately almost always a late secondary affection. From these considerations, it at once becomes evident that if the disease can be correctly diagnosed at an early stage, while it is as yet in the one kidney, a cure may be effected by a complete extirpation. It is because of this possibility that the diagnosis becomes a matter of such paramount importance.

It is evident, therefore, that the diagnosis keeps one eye squinting in the direction of an operation.

It becomes then the province of the diagnostician to take cognisance not only of the presence of the tuberculous affection, but of its extensions and its

limitations as well, determining with especial care, the great question whether it still remains localised in one half of the urinary tract. His task is not completed until he has further determined the condition of the opposite kidney, whether it, too, is tuberculous or otherwise infected, or whether it is attainted with a nephritis or an amyloid degeneration. He must determine in the course of his investigation the functional co-efficient of both kidneys, that is to say the amount of solids excreted by each in twenty-four hours. A diagnosis therefore cannot be considered as made until it has included within its realm of investigation the entire urinary tracts of both sides as well as the condition of the bladder and the urethra. The diagnostician must also search for other perhaps latent foci of the disease, in the male and female genital organs, in the lungs, in the superficial glands, and in the joints.

The great question of importance in every case of urinary tuberculosis is as to the accuracy and the thoroughness of the diagnosis; it is here, if anywhere, that the skill of the medical man is apparent; the worst clinical cases are often suddenly illuminated by a bright ray of hope when a careful diagnosis is made. In comparison to the difficulties encountered in making such an exhaustive analysis as is often called for, the operation is easy. In brief, the diagnostician has to consider:—

1. Has the patient a tuberculosis of the urinary tract?
2. Is the disease still localised?
3. If the diseased kidney is removed, is the remaining kidney able to do the work?

A satisfactory diagnosis is made when tubercle bacilli are found in the urine at more than one examination, and preferably by more than one observer, and when these are traced upwards to one kidney and positively excluded from the other. In order to do this the urine as it is collected from the bladder must first be examined, then the separated urines (I use the plural indiscriminately) must be collected near their sources in the pelves of the kidneys. The diagnosis must include both the character or quality of the infection, as well as the abundance of the bacteria, and the question of their constant or intermittent appearance in the urine.

In an advanced case with all the signs present the diagnosis is usually quite easy. The patient, often much emaciated and cachectic, has hectic fever, sweats, a rapid pulse, a furred tongue, and anorexia, with a more or less marked low hæmoglobin. There is as a rule constant vesical tenesmus, with the passage of urine loaded with pus and sometimes bloody. Palpation in the loin at once reveals, if it is not already manifest to the eye, a more or less manifest tumour on one side. On inspecting the body scars may be found in the neck, in the axilla or in the groins, or there may be a swollen joint, or distinct evidences of pulmonary disease. The family history in a large percentage of cases points strongly towards tuberculosis. On making a vaginal examination, an enlarged cord-like ureter, sometimes nodular, and sometimes so infiltrated and rod-like that it feels as though it would break under firm pressure, is felt through the anterior vaginal wall sweeping round the front of the cervix. Pressure upon this often induces an intense desire to urinate. The opposite fornix is, as a rule, soft and yielding, and here the practised touch readily detects the little normal yielding ureter slipping like a soft wet string between the fingers as it is handled bimanually or is pressed against the pelvic wall. If in a case presenting such earmarks tubercle bacilli are found in a specimen of urine taken from the bladder by a catheter, the diagnosis is assured, and it only remains to determine further the condition of the bladder and of the opposite kidney by a cystoscopic examination, upon which I shall dwell more fully a little later. While the diagnosis of tuberculosis, renal and ureteral, becomes more easy as the disease advances, with the increasing involvement of the bladder comes the difficulty of finding the opposite orifice and analysing the separated urines,

and so of differentiating the two sides, and when this is not done the diagnosis must be considered incomplete.

The cases most difficult of diagnosis are the early ones in which the bacilli are often sparse or appear in the urine only at considerable intervals. We are obliged here to depend upon repeated examinations of large quantities of urine (24 hours) allowed to stand, decanted and then the sediment centrifugalised. Sometimes the examiner finds the bacillus after many hours of search, repeated day after day. In this way one who has had experience and whose suspicions have been aroused by an otherwise inexplicable slight pyuria, will sometimes succeed where others have failed.

In all obscure cases one of the first steps should be to collect the urinary sediment and inject it into two guinea-pigs, one into the peritoneal cavities and one under the skin of the groin or axilla. If there is tuberculosis after three weeks the disease will have developed sufficiently to be recognised at autopsy. The injection of tuberculin is valuable if in addition to the fever induced there is marked local reaction in the form of intense pain in the kidney. A practised examiner will in these early cases often detect little thickening or hardening of a ureter on one side as compared with its fellow, which is significant and yet would ordinarily escape notice. It is in these doubtful cases, too, that the inspection of the ureteral orifices plays such an important part; a tell-tale blush or puffiness or granular condition will often mark the diseased side. The ureteral catheter may then be introduced and the urine from the infected kidney collected without dilution with that of its fellow.

In case the diagnosis is not clear, the physician can well afford to demand the important added element of time and observation putting off any thought of operation while he keeps his eye on the patient, from week to week, or perhaps from month to month.

Any persistent acid pyuria, as Caspar insists, even a mild grade, which does not yield an efflorescence of organisms of the ordinary culture media should at once be placed under the category of suspected tuberculosis, and the urine centrifugalised, and a test guinea-pig injected.

The following plan is used, adopted from Belgard, cited by Casper "Amer. Jour. Urology," 1904, I., 50]. The urinary sediment which has been centrifuged and washed with sterile water is injected both intraperitoneally and subcutaneously. The guinea-pigs should at first receive 0.5 of the old Koch's T.B. If they are tuberculous when this dose is given it is deadly. One then receives an injection into the peritoneal cavity of the washed urinary sediment mixed in about 0.2 sterile water. The other receives the same quantity subcutaneously. If the urine contains tubercle bacilli in from three to four weeks following the subcutaneous injection large palpable glands can be felt in the fore or hind feet according to the point inoculated. These glands have already begun to undergo cheesy degeneration and contain tubercle bacilli. The intra-peritoneal injected guinea-pigs develop a general miliary tuberculosis with characteristic nodules on the peritoneum, omentum, spleen, and in the lungs and kidneys. Any slight persistent cystitis rebellious to treatment should also always be suspected as a possible tuberculosis, and in such a case diagnosis must be looked upon as incomplete until the condition of the kidney has been investigated.

The Cystoscopic Examination.—I prefer to all other methods in these cases the direct aroscopic examination of the bladder. If that viscus is badly affected it is most difficult as well as oftentimes most painful to clear the bladder and distend it sufficiently to see all parts clearly, especially the ureteral orifices. It is also still more difficult if there is a tight ureter, as well as hazardous to attempt to catheterise the kidney through the medium of contaminated fluid. By my direct method I can see all parts, and I do not frequently mistake a painful bladder which screams when the effort is made to distend it for a contracted bladder, which is a rare bugbear in woman. I can also

cleanse the ureteral orifices before catheterisation, and use hard metal as well as flexible catheters of various sizes in dealing with a rigid ureter. The ulcerated, suppurating bleeding bladder is a common picture. An injected ureteral orifice, an ulcerated orifice on one side, a pocketed retracted orifice, a deep hole looking like a diverticulum (Fenwick's golf-hole orifice) often tell the tale and are finger posts to the side diseased. If one orifice looks sound while the other is in the midst of a diseased area, the case promises well.

In an advanced case when most of the work is being done by one side, the orifice shows twice the normal activity, and it is easy to catch the urine as it spurts out in the lumen of the speculum, and collect it below and subject it to a microscopic and bacteriologic examination. One may thus avoid catheterising the sound side, although I have yet to see any serious harm done by so doing. The diseased side may resist the entrance of the catheter, and when it is once engaged it may bite it so tight that it feels as if held in a vice. If the urine does not flow after the catheter reaches the kidney it may be started by injecting a little bland fluid. There is no objection to leaving one or both catheters in the ureters for an hour or more. The urine collected in this way may be used for bacteriologic as well as chemical and microscopic examination, as it is uncontaminated.

Let me here present in a categorical manner some of the alternatives to be borne in mind in making a diagnosis.

1. Is the organism found the smegma bacillus? How was the urine secured? Was it by voiding or by catheterisation?

2. Given the tubercle bacillus in the mixed urines, from which side does it come? Determine by catheterisation the appearance of the ureteral orifice and the thickened ureter.

3. Is the opposite side entirely free from disease? Bear in mind that a simple pyelitis is not infrequent in the opposite kidney.

4. Bear in mind that the opposite ureter may show marked thickening (peri-ureteritis) and yet the kidney be free from tuberculosis.

5. Note carefully to what extent the bladder is affected, as having an important bearing upon the operation, and the subsequent treatment.

6. Determine the urea co-efficient of the opposite kidney. Is it able to support life?

7. Look carefully for disease elsewhere. Is there a tuberculosis of the genital organs? Is there any pulmonary or glandular tuberculosis?

8. In injecting guinea-pigs remember that tubercle bacilli may pass out of the bladder if your patient has phthisis without injury to the kidney.

9. Remember that the enlarged kidney found in the loin may be the one functionally enlarged and therefore the only sound organ. Twice has such a kidney doing all the work of the body been taken out. There is a great risk of making this mistake.

With the information afforded by such a complete analysis one is then ready to proceed to the operation with confidence, or at least with full knowledge of the risks incurred.

TREATMENT.

Radical treatment, the extirpation of the disease in every case which will permit it. But before we bring the patient to this surgical crisis, again I insist such a thorough analysis of the separated urines must have been made beforehand that the surgeon shall be able to perform this capital operation (nephrectomy) without misgivings as to the capacity of the remaining kidney to sustain life. The supreme aim of surgery is conservatism, but in spite of some notable exceptions it has not done well here. The difficulty is that almost all tubercular kidneys contain scattered foci of infection which cannot be seen before the complete removal of the organ from the body. The late and eminent surgeon Christian Fenger tried a conservative resection of the kidney in a short series of cases, and the diseases recurred, and they died.

I would only be content to excise the diseased area in rare cases in which the disease was evidently limited to one pole as demonstrated by splitting the organ from end to end and down into the pelvis as it lay outside the body before ligation of the vessels and detachment.

Now, having spoken so strongly for radicalism, let me cite a few of the cases in which conservatism has proven brilliantly successful. Your own Morris had seven cases of partial nephrectomy, and in three of them a total nephrectomy had to follow. Of the remaining four, three were living and well 3½, 4½, and 2½ years later. The fourth case was a remarkable one which must afford that eminent surgeon considerable satisfaction; a woman had previously had one kidney excised, when she acquired a tuberculosis of the remaining kidney, and Morris excised one-third of its substance. She recovered and was living four years later in domestic service. In a case of Israel's reported as well, it was found after four years that she had a tuberculous ureter as well as kidney, and the bladder was involved, too.

Dr. Williams, of Rochester, did a partial nephrectomy on a man with a well-marked phthisis some four years ago, and he is well and working on a farm to-day. There is one group of cases of which several instances have been recorded, in which the tuberculosis affects one half of a double kidney with pelvis and ureter separated from its fellow which remains sound. Albarran had such a case, and I have one now under my care. I removed the double left kidney with its two pelvis and two ureters, one of which was perfectly sound. The patient was so ill with the advanced disease that I do not believe I could have done a delicate resection in this broadly fused organ.

She returned about a year later, and I was then able to determine that the opposite right kidney had two orifices opening into the bladder, one of which was sound, while the other was ulcerated, and I could feel two ureters per vaginam, one of which was greatly thickened; I could also feel the two ureters in the opposite side, the thickened one corresponding to the diseased half of the kidney removed. She would not submit to another operation without an amount of urging and an assumption of responsibility I did not feel warranted in assuming.

In stating that the general experience at present shows that extirpation is the wiser rule, I am aware that I have to overcome in the minds of many of my hearers who may not have studied this question minutely, the depressing effects of the early statistics, compiled at a time when the technique was ill-defined, the cases were always advanced, associated with pyogenic infections, and transperitoneal operations were frequent. Thus S. Gross in 1885 collected twenty cases with an immediate mortality of 40 per cent. and of the eight recoveries, only one was living after twenty months.

Dr. Newman (*Lancet*, 1900, I., 526) gives in a list of 125 collected cases, an operative mortality of 20 per cent. within the first month. Morris only lost five out of twenty-eight cases.

Albarran gives fifty cases without a death. In a series of thirty-five cases of tuberculosis surgically treated by myself or my associates and carefully studied by Dr. Hunner, there were four nephrostomies of which one died in eleven weeks; there were nine nephrectomies of which one died with evident involvement of the opposite kidney, six weeks after operation; there were nine nephrectomies and partial ureterectomies all living; there were thirteen cases of nephro-uretero-cystectomy all living; and three of nephro-ureterectomy, of which one died on the sixth and one on the fifteenth day. This, as you see, is no bad showing for so serious an affection treated so aggressively.

Albarran's splendid statistics show but two deaths in fifty cases.

Nephrotomy, or a simple incision of the kidney for drainage, has been thoroughly tried as an alternative to a nephrectomy.

Poussan, for example, cites sixty-three nephrotomies

with thirty-nine deaths from the progress of the disease within one year, of the remaining twenty-four some lived as long as ten years. Out of eighty-two cases so treated by Tuffier, with a mortality of 47.8 per cent., only two were cured. I had one case myself of an old cheesy tuberculous kidney in which nephrotomy followed with a thorough curettage was succeeded by a complete recovery, but this is not the operation of election, but of necessity. In its proper sphere, as a preliminary to a radical operation, nephrotomy is a precious life-saving measure. I have had several cases of patients carried in on stretchers after years of illness, apparently in the last stages of emaciation and hectic, two of them condemned to death by eminent counsel; a nephrotomy readily done in from three to five minutes without shock, under gas, gave immediate relief to the distressing symptoms, and enabled them to pick up and stand a radical operation at a later date. It is important in a nephrotomy to open up all the abscesses in both poles of the kidney.

The radical operations may be conveniently divided into five classes:—(1) In the early stages of the disease; (2) in advanced renal disease; (3) with involvement of the ureter; (4) with involvement of both ureter and bladder; (5) a group of anomalous cases in which the tuberculosis complicates a hydro-nephrosis or a calculous kidney.

Not to enter into unnecessary details before an audience of surgeons, let me state that I find the most satisfactory avenue for the exposure of the kidney in the absence of malignant disease to be the posterior lumbar triangle formed by the tendinous aponeuroses of the oblique muscles and lying just below the last rib. The boundaries of the triangle are the oblique muscles, the quadratus lumborum, and the eleventh and twelfth ribs. Above the triangle lies the covering of the latissimus dorsi and centrally lies the retro-peritoneal fat. An oblique incision about three inches long extending from the yielding spot in the angle between the quadratus and the rib, exposes the latissimus, which can be lifted like a lid or separated in the direction of its fibres, or simply divided transversely. The whitish area of the triangle apex down is then usually seen at once. A pair of closed forceps is pushed through and withdrawn when the golden yellow fat pops out. The opening is then enlarged by blunt force, pulling the muscles away from the quadratus. In this way, as a rule, an opening can be made large enough to remove the kidney, and give perfect command of the entire field without the ligation of a single vessel. An enlargement is easily effected by separating the external oblique muscle fibres, or by dividing them, making a sort of frying-pan incision.

Care must be taken throughout not to injure either the last dorsal nerve or the first lumbar lying under the shelter of the quadratus, but varying a little in its position.

It is pleasant here to acknowledge the debt we owe to Lennander for the emphasis he has placed upon the necessity of sparing the nerve trunks in the various lateral incisions in the abdominal parietes, so as to avoid such disagreeable sequelæ as anæsthetic, and paræsthetic areas and muscular atrophy.

In advanced disease when the kidney is much enlarged, it is not worth while to waste time trying to remove it intact, it is best to empty it at once reducing its size to a minimum, and then after irrigating thoroughly, to proceed to the extraction. The greatest difficulties are often encountered at the upper pole and on the right side in the intimate adhesion to the vena cava and the duodenum.

Extreme care is necessary in effecting a detachment at these points, proceeding slowly and under direct inspection. A duodenal fistula is a serious and often fatal accident. And this brings me to a most important point connected with the extirpation of the kidney in old suppurative cases. I would here urge the more extensive use of the intra-capsular enucleation (Ollier, 1883). Sometimes an operation which has bid fair to be hazardous in the extreme is turned into the simplest possible procedure by thrusting the fingers through

the dorsum of the kidney and then breaking through the kidney substance on all sides from within out as far as the tough capsule. By following this in every direction with one or two fingers, the kidney is soon separated on all sides down to the vessels at the hilum, which are then tied. This is practically the only possible method of enucleation in those instances of sclerosis of the surrounding adipose tissue.

Let us now look at those cases in which the disease has extended from the kidney down into the ureter. About a year ago Dr. Hunner, my associate, reported (*American Medicine*, 30th Apr., 1904) thirteen cases of nephro-ureterectomy, all of which recovered. In four of these, in which the ureter was felt like a whipcord, through the vagina, but a removal showed only a chronic ureteritis. I therefore recommend caution in adding the ureteral extirpation to that of the kidney. The cases best adapted to the more radical operation are those with a greatly enlarged, often strictured ureter. In my last case, a man operated upon just before leaving home, I left a large infiltrated ureter to be removed by a subsequent operation, as he could not stand more. The first patient operated upon by me in 1893, removing the left kidney and ureter as far as the pelvic floor, is living to-day without any return of the disease. Another operated on in 1895, removing the left kidney and its ureter by one long incision from loin to pubis, was well eight years later, and had borne two children.

I did my first operation freeing the kidney and the upper part of the ureter by a lumbar incision and then slipping the kidney under a wide intact bridge of abdominal muscles and extracting it with the rest of the ureter all in one piece through an opening low down in the abdominal wall, May 3rd, 1898. It is a greater pleasure, however to accord the priority for this advance in our technique to Berlin's great renal surgeon, Israel.

A. Schwyzer (*St. Paul Med. Jour.* Jan., 1905) has effected this removal by making a long incision above the kidney and the upper ureter and a vaginal incision to free the lower end of the ureter. When the ureter is entirely free the fingers in the abdominal and those in the vaginal wound meet, and the organ is extracted above.

Nephroureterocystectomy.—One of the most serious local extensions of the disease has from the first been deemed an involvement of the vesical walls, and a number of surgeons have considered cases of this character as beyond the pale of radical relief. My own work in some desperate cases has taught me that with careful surgery almost no case is beyond radical relief so long as the disease remains confined to the urinary tract of one side, and the bladder; and to this may be added a non-tubercular pyelitis of the opposite side. Two of my cases looked exceedingly hopeless, and had been given up to die; both were emaciated by months of night vigils, and constant intense suffering with tenesmus, and one did little else than lie moaning like a distressed animal, screaming if she was touched in the vagina, and soaked in her offensive involuntary discharges. The bladder was contracted ulcerated, bleeding, and uniformly of a deep angry red colour characteristic of an active universal cystitis. The first step was to relieve the pain, and that was done by making a large vesico-vaginal fistula. Next, the tubercular kidney, with its thickened ureter, was taken out, then in one case a large part of the bladder was excised, and subsequently another piece was taken out, both times suprapubically, between $\frac{1}{4}$ and $\frac{1}{2}$ in all. The fistula was closed, the bladder was irrigated and distended, and in the latter case the remaining kidney was irrigated. Both recovered over a year ago, and are now well women managing their respective households. I cannot insist too strongly on the value of the prolonged bath at an even temperature of 100 F., for hours or all day, as devised by Dr. Hunner for these cases, especially if the vagina is patulous.

The steps, then, are these:—(1) Drain a bad bladder thoroughly; (2) then remove kidney and ureter;

(3) use the bath when possible; (4) close the fistula; (5) treat any remaining small particles of the disease with nitrate of silver applied through the open-air speculum; (6) use distension and irrigation treatments; (7) excise any rebellious areas of disease.

As a matter of fact, the small patches of cystitis and the little areas of disease around the ureteral orifice are rarely tubercular, and this is the reason they clear up so readily without further treatment after a nephrectomy.

THE TREATMENT OF INGUINAL HERNIA IN INFANCY AND CHILDHOOD.

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(Concluded from page 641.)

II.—OPERATIVE TREATMENT.

TURNING our attention to the operative treatment of hernia, we have to consider the risks of the operation itself, its results, and the length of treatment involved.

The danger to life from an operation for radical cure of reducible inguinal hernia I consider to be very small, practically nothing more than the risk which must always accompany the administration of a general anæsthetic. I have now performed the operation seventy-nine times, with one death. This occurred from pneumonia on the third day after the operation, without any signs of inflammation about the incision. Although I cannot get over the fact that this child died after an operation for the cure of hernia, and that he would probably not have died had this operation not been performed, at the same time I am bound, in fairness to the procedure, to explain that two cases of pneumonia were occupying the same ward, and that the child had a slight cough at the time of operation, which was considered so trivial as to warrant its not being reported to me.

The results of the operation are thoroughly satisfactory. The cure is really a radical one. I take the greatest care to impress upon all parents the necessity for letting me know if a tendency to the return of the rupture is noticed, at any time, after the operation. I can only say that I have not yet heard of, or seen, any case on which I have operated where this has occurred. Some of my cases were operated on seven years ago. I cannot, of course, say that no case of hernia operated on in infancy or childhood ever recurs; but I have taken the best pains to ascertain if it has done so in my own series of cases, and I have not yet found one in which this disappointing result has followed.

The duration of treatment is three weeks; after that time I allow the patient to be up and about, and no truss requires to be worn.

Under the following circumstances I do not hesitate to recommend operative treatment in infants:—

Where the hernia is associated with undescended testicle; where the rupture is very large and the inguinal canal widely dilated; where a well-fitting truss fails to retain the rupture after gastro-intestinal disturbance, phimosis, &c., have been cured, and in cases where a truss causes excoriation owing to carelessness or inability in management.

I am becoming more and more impressed with the fact that infants stand operations well, provided that they are kept warm, lose little blood, and are not exposed to the action of strong antiseptics during the course of the operation.

The objection that soiling of the dressings, and consequent suppuration of the wound, is difficult to prevent in young children who have not control of the evacuations, is without foundation. By very simple means, such as I shall immediately describe, this untoward occurrence can be easily and effectually prevented.

In children over the age of one year the greater reliability of operative measures and the rapidity of

the cure, compared with the tedious and uncertain treatment by trusses, leaves no room for doubt as to which is the more satisfactory treatment.

The method of preparation for the operation which I have found most satisfactory is as follows. The child is bathed the night before, and thoroughly washed with soap and water over the front and sides of the abdomen to above the level of the umbilicus, the thighs in their whole length and special attention is paid to the penis and scrotum. The same area is next carefully gone over with ethereal soap; and subsequently with a 1-500 solution of biniodide of mercury in methylated spirit, with a 10 per cent. addition of glycerine. After this the parts, with the exception of the penis, are covered with a wet dressing of saturated boric acid solution over which mackintosh tissue and a bandage are applied.

The child is then tied down in bed and a bottle placed between the legs to catch the urine, in those cases in which control of the bladder has not been gained. The accompanying illustration shows the method employed. It is astonishing how, in an hour or two, infants and young children seem to become accustomed to the constraint. It is advisable so to arrange the child the evening before the operation, in order to prevent the preparatory dressing being soiled by urine during the night. The child thus becomes accustomed to the constrained position before the operation.

The following morning the boracic dressing is removed, the parts washed with biniodide solution, and 1-80 carbolic acid wet dressing applied, which is not removed until the child is on the operating table an hour or two afterwards.

To prevent the child catching cold during the operation, warm stockings, and a woollen vest with long sleeves, should be worn. In the hospital I have a table which is warmed with hot water; in private practice hot-water bottles, placed under the blanket on which the child lies, serve the same purpose. The



temperature of the room should be at least 65°, and all draughts carefully avoided. Small children lose heat rapidly, and great care must be taken to prevent it.

I operate aseptically; no antiseptics are brought into contact with the wound. My instruments are placed in boiled water, and the gauze dabs which I use are sterilised by steam and used dry; the operation area is surrounded by linen sheets prepared in the same way. The important point about the line of incision is that it should not encroach at all upon the scrotum. The penis is kept carefully covered with a piece of sterilised gauze. The only vessels which are divided are the superficial epigastric and superficial external pudic; these can always be seen in the line of incision and clamped before division; in this way practically all loss of blood is avoided.

The sac is first recognised at the external abdominal ring, and is then pulled up until its lower limit is detected, after which it is rapidly separated from the cord. This separation is carried up to above the level of the internal abdominal ring. A fine catgut ligature is then applied to the highest part of the sac, the lower

part is cut off, and the stump then retracts beyond the internal abdominal ring.

The closure of the inguinal canal is obtained by one or more sutures passed through the conjoined tendon and inner part of Poupart's ligament, behind the cord, after Bassini's method. If the external ring be very large, a suture may be necessary to approximate the pillars.

Although, as a rule, I take these steps to close the inguinal canal, I am sure that the high removal of the sac, allowing the stump to fall back into the abdominal cavity, is the essential point in the performance of a radical cure in children. In support of this statement, in operating in eighteen consecutive cases, I made the experiment of thoroughly removing the sac and leaving the inguinal canal untreated. In none of these children did the rupture recur. At the same time, closing the inguinal canal must be an additional safeguard, and I generally put it into practice. The wound is closed without drainage.

I use a sterilised gauze dressing wrung out of 1-60 carbolic. I think it advisable to employ a mild antiseptic at this stage, as it would appear to check the development of the organisms which are always present in the skin, and so diminish the tendency to supuration about the stitches. Sterilised wood wool is then applied, and a crossed perineal bandage put on, covering in the scrotum. This prevents subsequent œdema, and avoids the possibility of the inner end of the incision getting exposed, as I have often seen occur when a spica bandage alone has been applied to the side operated on. The anterior part of the bandaged area is then covered with mackintosh tissue pinned over it, a hole being cut for the penis.

Immediately the child is put in its cot it is tied down, and a bottle placed between the legs, and fixed by tapes passed round the pelvis, in the manner which I have described.

It is quite unusual that the dressings have to be changed owing to soiling; with good nursing it practically never occurs.

The results of the above technique, as indicated by the healing process, have been as follows:—Of the seventy-nine cases operated on, seventy-one healed without any inflammatory complication. Three cases suppurated and, in five, small superficial stitch abscesses occurred. The ages of these children ranged from three months upwards. The figures indicate that, taking proper precautions, healing by first-intention can almost be guaranteed. In infants, as soon as the stitches are removed, the child can be carried about and taken out. A bandage cap should be worn for three weeks after the operation. Older children should be kept lying down in bed for three weeks; they may then be allowed up, wearing a spica bandage for another fortnight. In no case is it necessary to recommend that a truss be worn after the operation.

My experience, then, of the treatment of reducible inguinal hernia in infancy and childhood, has brought me to the following conclusions:—

I.—That truss treatment is only to be recommended during the early months of life, and, even then, that it is tedious and uncertain.

II.—That operative treatment is the only *certain* method of cure after the first year; that its risks are small, and the duration of treatment short.

III.—That there need be no hesitation in operating during infancy on account of the danger of suppuration following upon soiling of the dressings.

Strangulated inguinal hernia is relatively uncommon in children. Its frequency increases with the age of the child, owing to increasing resistance of the structures forming the inguinal canal and rings. Strangulation may, however, occur very early in life; the earliest case I have met with was in an infant seventeen days old. In the majority of cases a reducible inguinal hernia has been present for some time before strangulation occurs, or strangulation follows the sudden re-appearance of a hernia which has been treated, and apparently cured, by a truss.

As regards treatment, the urgency is, if possible, greater than in similar cases in adults, owing to the rapid necrotic changes which follow the interference with the circulation in the delicate, thin-walled bowel of children, and the early appearance of severe shock.

No time should be lost in the application of cold with elevation of the legs and pelvis. I have not seen any benefit result from this form of treatment, and I consider that only harm can follow its employment owing to the delay involved.

With regard to taxis, it should never be tried until the child is anæsthetised and everything prepared for operation. It may then be employed very gently and for a few minutes only, the child being held up by the legs during the manipulations. Should taxis fail, as it almost invariably does, operation is immediately proceeded with, the strangulation being relieved and a radical cure performed. The older the child, the shorter the time of strangulation, and the less prolonged the attempt at reduction by taxis, the better is the prognosis in such cases.

THE USE OF PESSARIES UNDER DIFFICULTIES.

By J. E. BURTON, M.A., L.R.C.P.LOND.,

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THE object of this paper is to show that the practitioner need never despair of using a pessary successfully in any needed case, so long as he wishes to treat the case by simple means, and he is willing to follow the line of treatment laid down in it.

It is curious that there should be such divergences of opinion as to the usefulness of pessaries. Some gynæcological surgeons think them of but little value and look upon efforts to treat displacement of the uterus by them with something of scorn and as beneath serious consideration. Others, on the other hand, place great reliance upon them; and are firmly of opinion that only a small minority of cases of displacement cannot be treated successfully by them. They acknowledge, however, that some little study is required in each case, and that it will not be enough to insert any kind and size of pessary for any kind of displacement. I confess with some feeling of shamefacedness, perhaps, that I place myself in the ranks of the latter class. I feel quite satisfied in my own mind, from my own experience, that with care, forethought, and some little ingenuity, the cases that must, perforce, be relegated to that refuge of the destitute, ventrofixation will be very small indeed.

A well-fitting pessary that does its work, if made of vulcanite, or celluloid, or metal, is only very slightly inconvenient to its wearer, not nearly so much so as a plate of artificial teeth in the mouth. Very frequently the patient can be taught to take the pessary out, clean it, and reinsert it herself. I have had numbers of patients who have taken them out every night, or nearly so, and put them back in the morning before rising from bed; and others who, not having courage or knack, have come at intervals longer or shorter, to have them attended to. But the wearing of a pessary means that the parts must be kept clean by regular vaginal douches, just as the mouth and teeth must be kept clean by the daily brush and wash. Otherwise discharges will collect in the angular trough formed by the junction of the pessary and the vaginal wall, and become foul. In passing, I may say that there is

no better or more readily procurable material for the douche or syringe than bicarbonate of soda. A teaspoonful of this, dissolved in each pint of water, does not coagulate the discharges as alum does, and it keeps both vagina and pessary clean. Of course, if any astringent is required it must be used, but it must be *after the wash-out with the soda and water*, not whilst the coagulable discharges are still lying in the vagina.

To return, pessaries can be made to rectify almost any displacement, and the inconvenience of such supports can be reduced to very small compass. This being so, the question very naturally follows—Why are they looked upon with so much disfavour? and why is ventrofixation, so simple and easy of performance to the gynaecologist, but not always so simple, or safe to the patient, so often resorted to in place of them? To my mind, there are two reasons, one being that the gynaecologist frequently will not take the trouble to treat the case successfully with a pessary, and, secondly, that there is an alluring finality about the stitching operation that the other method of treatment does not possess. Instead of saying finality, I should have said an appearance of finality, for I think the finality is elusive and not arrived at nearly as frequently as the operator would wish.

In the great majority of cases, prolapse and backward displacements are treated easily enough by any medical man with a simple Hodge's pessary, but in many the treatment is not so simple. (In parenthesis, I should like to remark that in my opinion the pessary made use of by the general practitioner is often larger than is necessary, and on the other hand I have seen them so small that they could not be of the slightest use.) The pessary perhaps comes out, or the displacement may remain as it was before the instrument was inserted, or, worse still, the pessary may cause so much pain that its use has to be discontinued. In the treatment of these more difficult cases the first mistake is to attempt to treat them as out-patients. No man will be successful in treating cases of this class without first putting his patient to bed, in the more favourable cases for two or three days, and in others for a longer period. We all know what a difference two or three days' rest in bed makes in the feel of a woman's pelvic organs. Before putting her to bed everything may feel tight and pressed down, whilst after a period of rest everything in the pelvis lies loose and movable.

My general rule has long been in case of the least difficulty about the retention of a pessary, to put the patient to bed for two days, enjoining her to lie in the horizontal posture; then on the third day to insert a pessary, usually a Hodge, taking care that it shall be of the proper size and shape. As regards size, when inserted and pushed up gently into the posterior vaginal arch, it should readily allow the forefinger to lie between the lower limb and the os pubis. By taking care in this manner, we know the pessary will be an efficient support, and at the same time there will be no danger of its causing ulceration through improper pressure on any one part. My rule further is to still keep the patient in the same posture for another twenty-four hours, when she is allowed to get up. By taking these precautions the pelvis is prepared by the forty-eight hours' rest, with all pressure removed from its organs for the

reception of the pessary, and during the next twenty-four hours the pessary is making a suitable bed for itself, from which it will not be readily shifted, and where it will give efficient support without causing pain. It will only be at rare intervals that any other kind of treatment will be called for. Nevertheless, such cases will occur, and a little ingenuity and patience may be called for.

A woman may have a small fibroid in the fundus of the uterus, she may have inflamed and dilated Fallopian tubes, or inflamed and tender ovaries, or she may have had perimetritis, and the uterus may be adherent in almost any direction. In all these cases a preliminary course of treatment, whilst the patient lies in the horizontal posture, is a necessity. In the case of the fibroid it is true much may not be required. But the presence of the fibroid will not be the only thing to contend with. The fundus will be hypertrophied and perhaps tender. Here the case must be treated according to the symptoms present. If the hæmorrhage can be kept within moderate limits so as not to make the patient a complete invalid, and the change of life is within reasonable distance, it would not be true gynaecology in my estimation to subject such a patient to any mutilating operation, irrespective of any danger to life that might be entailed by it. Medicines can be made to do a great deal for uterine myomata, but that is another story, as a writer puts it. With a fibroid there, and an unusually top-heavy uterus, an ordinary Hodge may not be sufficient to keep it in position, and if it is not kept in position the metrorrhagia will get worse; and so another form of instrument must be tried. Although prejudiced at first against such refinements, I was at last induced in one difficult case to try a soft hollow rubber Hodge, the hollow being filled with gelatine. It answered admirably after all vulcanite pessaries had failed. The metrorrhagia, *i.e.*, after the requisite rest treatment had been gone through, got at least no worse—rather less of the two—and the tumour did not increase materially in size. Care must be taken in such cases, however, that the support does its work, and as it has much more to do than under ordinary circumstances, and the consequences of failure on its part may be serious—and very serious—it will require more careful supervision than in simple cases. Of course, when the change of life does come the case will probably soon resolve itself into one of the more simple kind.

In the case of inflamed or dilated Fallopian tubes, or inflamed prolapsed and tender ovaries, it will not be necessary to remove these, but they must be treated by rest and soothing local applications, and for a lengthened period, two or three weeks at least. A useful application is boracic acid powder, kept in place by a tampon, or a solution containing 5 per cent. of glycerine with 3 per cent. of ichthyol in succus conii may be employed. Alumol also is a very useful application. In all probability two or three weeks' treatment in this way will reduce the tenderness of the pelvic organs so far that a pessary may be inserted. But the patient must not yet be allowed to get up. In cases where the difficulties have been as great as those just described, she should not even be allowed to sit up in bed for two or three days longer—in fact, not until all local tenderness has disappeared. When all pain and tenderness

have subsided and the support feels comfortable to the patient, a cautious attempt may be made to get her up.

Of course, with all this, strict attention must be paid to the regular action of the bowels. Perhaps no one thing is more likely to keep up congestion in the pelvis than constipation, and one of the best aperients in such cases is sulphate of soda.

All that has been said naturally presupposes that no active inflammatory mischief is going on as evidenced by heightened temperature. If so, no one would think of introducing a pessary until all such symptoms had subsided and the temperature had remained normal for at least a week. This has always been my custom, perhaps I have erred on the side of over-carefulness, and given myself and the patient unnecessary trouble; but so far I have never had cause to regret it, and I have not the slightest intention of changing it for a more go-ahead system. It is better to be over-cautious than not cautious enough. In regard to this, I hope I may be pardoned for referring to certain proceedings of others. I have known two surgeons, both good surgeons, and both doing a good deal of work in herniotomies. Both had equally good recoveries as far as I know, and the only difference in the treatment of their cases was this: One of them allowed his patients to get up in a fortnight if the wound healed by first intention; the second one, even in most favourable conditions, insisted on his patients keeping on their backs for six weeks instead of two. In the case of the latter surgeon the wound got consolidated and firm and held well when the strain was put upon it; in that of the former the wound was too frequently weak, and the unconsolidated tissues stretched so that the hernia was not cured. By hurrying, he really got on more slowly than the more slow-going surgeon. It is the same with pelvic inflammations.

I have not spoken of operation cases. Cases requiring operation if they have been treated in the manner indicated, will be few and far between, and I look upon it as a great reproach to surgery to mutilate or remove natural parts, when all symptoms can be relieved and permanently so, without recourse to laparotomy, and where, by the exercise of a little patience and a little extra trouble, such necessity could be avoided. The time must soon come when extirpation of natural parts, ovaries, or tubes, for simple inflammatory disease will almost cease, and women will be allowed to retain their integrity almost as much as men.

We now come to the class of case in which the uterus itself has contracted adhesions, or the adherent Fallopian tubes prevent the fundus rising under the pressure of the pessary. Here in the first instance, after keeping the patient at rest in bed, a pessary may be inserted considerably larger than the one intended for more permanent use; or a large elastic rubber ring may be introduced in the way Sir W. Sinclair treats his cases of retroverted gravid uterus. This may stretch the adhesions; but a pessary of such size cannot be borne long. Such an one should never be allowed to stay in longer than twenty-four hours without being carefully looked after. If the pessary is an elastic one it will be doubly dangerous as it will ulcerate into the vaginal walls in a very short time. If this method fails after full trial, another mode of procedure may be adopted, and

it will, I have no doubt, in most instances prove effective. At any rate, that has been my experience, and I have only rarely of late ever had to resort to cutting operations, either ventro-fixation or Alexander's operation, although (by way of parenthesis) of the two the latter to my mind is far and away to be preferred to the one requiring abdominal section. In my opinion, also, any one who has once got the knack of doing Alexander's operation—and it does require some little dexterity—will never turn from it to its more fashionable (?) rival. For one thing it has absolutely no bad results in subsequent pregnancies.

The procedure I allude to is known as Schultze's operation, and it consists in separating adhesion-bi-manually, the patient being under an anæsthetic. It is very easy to do in thin people if the abdominal walls are sufficiently relaxed, and not difficult even when the walls are fairly thick. The patient is placed in the lithotomy position, and, as said before, the abdominal walls must be well relaxed. With two fingers of the one hand in the vagina, the uterus is pushed up, and with the other hand outside the fundus is sought for through the abdominal walls. When found, the fingers of the outside hand must be pressed deeply *behind* the uterus until they meet the fingers of the inside hand that are also behind the uterus. Both hands are then used to lift up the uterus and draw it forwards until it touches the os pubis; it is then worked about a little until it is felt to lie free and unattached. A fairly good-sized Hodge's pessary is then inserted in the usual way and the operation is over. One necessary precaution should be here mentioned. After being put to bed, the patient must not be touched again for a week. If adhesion really existed, they must have been torn through, and there will be some internal hæmorrhage. The peritoneum will also be in an irritable condition, hence the necessity for rest and quiet. Whenever the precautionary rest has been given I have never seen the least sign of harm following the operation. In one early case, however, I did not adopt the precaution, and my reward was a smart attack of peritonitis, but from which the patient made a good recovery. The case was a warning, however, which I have never since disregarded. It is remarkable how little constitutional disturbance follows the operation. There is scarcely ever any rise of temperature, and at the end of the week the patient will be found to be comfortable with her pessary, and the uterus will be in its normal position, and after this there is scarcely any trouble.

If the lines laid down are intelligently and perseveringly followed, it will be found, I feel sure, that no cutting operation will be required. In the case of a patient likely to go abroad, the circumstances will be different, and it will be well to put her in a position in which no pessary will be necessary, unless she feel equal to the occasion of taking out her pessary and cleaning and replacing it.

As already stated, the chief difficulty in treating a patient with a displacement which happens not to be amenable to routine treatment, lies in not recognizing the necessity for rest in bed, and in consequence in continuing to treat the case, whilst she is going about as usual. Such a mistake if persisted in must bring treatment by pessaries into disrepute.

It is this preliminary rest that often furnishes the key to the situation. It is not sufficiently insisted on either by teachers or in the text-books, and I feel sure that if the general practitioner recognised it and realised the value of it the pitiful operation of ventrofixation would fall into desuetude and Alexander's operation would be found sufficient to meet all the requirements of the very few cases that did not yield to the treatment sketched out.

To sum up: (1) Perhaps the majority of displacement cases can be successfully treated as out-patients, by ordinary routine methods. (2) A considerable number will require a preliminary rest in bed before the pessary is introduced, and for twenty-four hours afterwards. (3) Some will require preliminary treatment of pelvic inflammation before a pessary can be inserted with reasonable hope of success. (4) A still smaller proportion complicated by adhesions will require separation of these and freeing of the uterus before a pessary can be successfully made use of. (5) Schultze's method is an exceedingly good one for separating such adhesions; it is one which I have frequently made use of, and from which no harm has ever resulted so far as my personal observation has extended.

Finally, I hope these remarks, founded on a good many years' experience, will lead to some rehabilitation of the pessary, and encourage my colleagues to more patience in pessary treatment, in which case I feel sure many suffering women will be saved from mutilating operations.

Transactions of Societies.

BRITISH GYNÆCOLOGICAL SOCIETY.
MEETING HELD THURSDAY, JUNE 8TH, 1905.

Dr. WILLIAM ALEXANDER, President, in the Chair.

DR. HOWARD KELLY (of Baltimore) read his address on "Tuberculosis of the Urinary Tract in Females." (This will be found fully reported on page 663 of the present issue.)

Dr. MACNAUGHTON-JONES said: Ours is a twin branch of medicine, including obstetrics and gynaecology, and we, as a Society, deal especially with the latter of these. It is, I think, a fact that the world owes most to Great Britain in the practical art of obstetrics. Chamberlayne gave us the forceps, and there are no names that we can place side by side equal to those of Smelley, Blundell, Denman, Oulde, and Simpson. On the other hand, in the practical and clinical side of gynaecology, the world is most indebted to America. Ben McDowell gave us ovariectomy, Marion Sims the duck-bill speculum and all the various plastic and other operations associated with his name, not to mention those on the urinary organs which Dr. Kelly has referred to in his address. Emmett's name was familiar to everyone for his plastic surgery, and the operative treatment of lacerations and fistula. Gaillard Thomas was a prominent worker in the infancy of gynaecology in connection with uterine displacement, and his operation for the cure of inversion of the uterus was the first important operative step in this direction. From America we had received the most ingenious devices for support of the uterus, and the names of Cutter, Hodge, and Fowler were well known to all in the construction of pessaries. Cutter had been the first to use electricity in the treatment of uterine diseases and he and Tripiet had anticipated Apostoli. Skene had been the first to use electrohæmocoæsis in the removal of uterine tumours and the adnexa; Weir Mitchell had given us the treatment of reflex neuroses by rest, blood-making, and massage, and the most perfect instrument in the whole range of gynaecological appliances was the recently constructed

electro-caustic angiotribe of Downes. Fordyce Barker and Engelmann were pioneers in the elucidation of questions bearing on the mental correlations of affections of the genitalia, and those others which bore on maternity and the race. Edebohls had, coincidentally with Christopher Martin in this country, advocated complete removal of the vagina in incurable prolapse, and to him also was due the credit of decapsulation of the kidney in Bright's disease. Bovée's name was associated with operation on the utero-sacral ligaments in prolapse. One of the brightest medical intellects of America was Pryor, whom they had recently lost, and whose special operation on the uterus in cases of cancer was so widely known. Dudley's operation for the treatment of dysmenorrhœa was another original step, and there were a host of other men, such as Byford, Goodell, Baldy, Charles Noble, and Clarence Webster, all of whom were original workers, while in the etiology of cancer and the elucidation of the parts played by the lymphatic system in its spread, no recent work had surpassed that of Cutter, Emil Ries, Gellhorn, and Wakefield.

Now, what had Howard Kelly done for gynaecology? His operation of supra-vaginal hysterectomy was one which they were performing every day; his operations on the introitus in cases of relaxed outlet and complete tear were familiar to all, as were those of fixation and suspension of the uterus, also, his advocacy of myomectomy and his methods of enucleation, and various other improvements in operative technique. But in no department in gynaecology was his name better known than in those affections of the urinary organs on which he had just given us such a masterly, lucid, and eloquent address. He stood absolutely alone in his manipulative skill in dealing with affections of the urinary organs, from the diagnosis of a tuberculous ureter to a calculus in the kidney. A great English poet had said:—

"Most men eddy about here and there,

Chatter and love and hate,

Gather and squander, are raised aloft,

Are hurled in the dust,

Striving blindly, achieving nothing,

And no one asks who or what they have been

More than he asks what waves

In the moonlit solitude wild in the midmost ocean

Have foamed for a moment and gone."

Not so their visitor to-night; not for him to be "lost in the crowd," not for him "the eddy of purposeless dust," but his to lay one more solid stone in the sure and firm foundation of the twin edifice of obstetrics and gynaecology. He (Dr. Macnaughton-Jones) had much pleasure in proposing a vote of thanks to Dr. Howard Kelly for his admirable address.

Sir WILLIAM JAPP SINCLAIR: Mr. President, Ladies and Gentlemen,—After listening to the admirable address from Dr. Kelly and the eloquent account of his work and of American gynaecological work generally, I feel that I am in a very difficult position, and cannot really do justice to the opportunity which has been granted to me in such a friendly way. However, without being eloquent, one can be heartily sympathetic and I do not exaggerate when I say that everyone of us has listened with great satisfaction to this address, and we must all go away better informed by it. It has been a great gratification to hear the subject discussed in such an efficient way. The lecturer has given the general practitioner something to grope at, but some thing at the same time, in regard to which, those who grope at it will not be able to conceal that they do not know anything about it. Dr. Kelly has told us that he is eminently practical and that suggested to me a difference between this country and America. He said that for diagnostic purposes he inoculated guinea-pigs. There is a very strong prejudice in this country against the most gentle use of the lower animals; in fact, one might inoculate human beings, but not guinea-pigs. (Laughter.) I had the exceptional advantage a great many years ago of being introduced to the subject brought before us to-night at Montreal, and I learnt more from the practical demonstration which he then gave than from any amount of lectures

on the subject. Dr. Kelly is an original man. The reason, I think, why we do not loom so large as America and Germany in medical science is because when a German or an American discovers anything they are patriotic about it, and make the most of their own country without any feeling of prejudice against one another. In our own country there is a little tendency, I am afraid, to run one another down. I will not detain you longer except just to add that in seconding this vote to Dr. Kelly I am quite sure I express your feelings when I say that we are very grateful to him for the service he has rendered to British gynecology by the admirable address which he has given us here to-night. (Applause.)

Dr. MENDES DE LEON (Amsterdam): Mr. President, and Ladies and Gentlemen,—After what has been said by the two previous speakers there is very little for me to add. I must thank you for calling upon me to support the vote of thanks, because I have an opportunity personally of expressing my admiration for the most interesting paper that we have listened to on this occasion. Dr. Kelly may be assured of the satisfaction of knowing that not only in England, but in Holland he and his work have a great number of friends and admirers. (Applause.)

Dr. HAULTAIN (Edinburgh): I may say it is a peculiar pleasure to me that I have been asked to support this vote of thanks to Dr. Kelly. We all know him, in that far distant part of the world that we know as Scotland, where he has so frequently come and treated us to an address of a character similar to that which he has given us to-night. Though it is some distance, I felt it was no trouble for me to come and hear him, and by coming I am able to convey to him not only my own thanks, but also the thanks of those other members of the Scottish part of the Society, who, if they had been able to be here, would have greatly enjoyed the address which Dr. Kelly has given us to-night.

The PRESIDENT, in conveying to Dr. Kelly the thanks of the meeting, said their visitor had informed him that he had come over to this country to rest. But the first thing you give us, continued the President, is this able address. You are one of our American cousins, and we take liberties with them. (Applause.)

Dr. HOWARD KELLY: Mr. President; and Ladies and Gentlemen,—I was not far wrong when, at the beginning of my address, I expressed the hope that I might have the pleasure of enjoying here something of the collegial fellowship for which the American profession is so noted the world over. Dr. Sinclair touched a note which lies very close to my heart. I pride myself always on being a close observer of men. In my own country I should just like to go round preaching medical sermons to the profession at large, and I am sure the medical sermon would be not *mal a propos* in other parts of the world as well. Wherever I go I notice that wherever men cordially support one another, and there is a great deal of warm affection among men in the profession, there medical work flourishes and medical science stands at its very highest. I could speak of some towns in America as examples where I know the medical men speak well of one another, and, in fact, live and work together like brethren. On the other hand, I think of other places there including one of the largest cities, where there is a great deal of competition and jealousy amongst the medical profession. It was so in Baltimore twenty years ago. That was the condition of things when William Osler first came there, but as a result of his influence there was not any jealousy or unkind feeling among them when he left. In order that medical and scientific workers may be made, we must get back to moral foundations in all branches of society. The world needs it, your country and my country need it above all others. Moral quality is just what has helped little Japan to-day, and that is what we require. I feel that the best word I can give to any medical community is this: Get back to the moral quality as the foundation of your work, and then work out from that into all the avenues of various useful activities.

France:

[FROM OUR OWN CORRESPONDENT.]

Paris, June 25th, 1905.

ANTISEPTIC, ANALGESIC, AND HÆMOSTATIC OINTMENT.

PROFESSOR RECLUS in one of his recent clinical lectures took for his subject the ointment he usually employs for wounds of all kinds and burns, and which combines a threefold action—antiseptic, analgesic, and hæmostatic. This ointment is based on the principle that wounds, burns, or ulcerations of every kind can be painful, can bleed, and can become infected. An application in order to be of service should combat all these complications. His idea was consequently to combine, in the same vehicle, vaseline, antiseptic, analgesic, and hæmostatic substances.

The first condition to be realised in an antiseptic ointment is to be sufficiently powerful, and the best way to attain that end is to multiply the antiseptic substances. It is well known that microbicidal agents do not simply add but multiply their effect; it is not the sum of the co-efficient action of each of them, but much more than that sum is obtained by their union. Perhaps each one possessed an elective action on a certain special germ, and that was why a good formula should comprehend several antiseptics.

On the other hand, it should not be forgotten that powerful antiseptics are dangerous, and the more so when the tissues are exposed. Antiseptics are poisons, and it was on account of the danger they caused that asepsy was substituted.

A selection should consequently be made amongst those substances which were the least dangerous on account of their small absorbent power, such as boric acid and salol, and if iodoform, phenic acid, or corrosive sublimate is used, it should be in small quantities.

Analgesic and hæmostatic action would be obtained with antipyrine, which relieves pain and arrests hæmorrhage. The pomade which seemed to M. Reclus the most apt to fulfil all these conditions was as follows:—

Antipyrine, 1 drachm ;
Boric acid, $\frac{1}{2}$ drachm ;
Salol, $\frac{1}{2}$ drachm ;
Iodoform, 15 grs. ;
Phenic acid, 15 grs. ;
Corrosive sublimate, 2 grs. ;
Vaseline, 7 oz.

The ointment, on account of the iodoform, might inconvenience some patients by its penetrating odour; in that case iodol might take its place.

Where large ulcerations were to be treated or extensive burns, the amount of vaseline might be increased two or threefold, but the doses of the active substances should remain the same.

The above preparation is used by M. Reclus in every case when the skin is broken, either from wounds, sores, ulcers, burns, etc. It is especially useful in the extensive wounds observed in crushed limbs. After washing the raw surface with hot water (130° F.), to remove all foreign bodies and destroy the microbes, the parts are sprayed with oxygen water, and finally the above ointment is applied to all the surface on antiseptic gauze and the parts put up in absorbent wool. By this treatment, concluded M. Reclus, many limbs have been saved which otherwise would have been sacrificed to the surgeon's knife.

TREATMENT OF ERYSIPELAS.

The following will be found useful:—

Guaiacol, 1 drachm.
Tincture of iodine, 1 drachm ;
Ether, 1 drachm ;
Menthol, 0.10.

Paint the surface three or four times a day.

Camphor, 30 ;
Cherry laurel water, $\frac{1}{2}$ drachm ;
Almond emulsion, 4 oz. ;
Syrup, 1 drachm ;

A tablespoonful every two hours followed each time by a warm drink.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, June 25th, 1905.

At the Society for Innere Medizin, Hr. Hans Elsen discussed the subject of

COLITIS MUCOSA AND COLICA INTESTINALIS.

The disease was a complex one, the characteristic of which was the discharge of mucous membrane through the bowel. The disease was first described by V. Leyden in 1882, the case being that of a woman *æt.* 50, who had periodical attacks of violent colic, especially on the left side, and after the attacks large quantities of mucous membrane were passed per rectum, which were scarcely at all mixed with feces. In the free intervals no membranes were passed. It was at one time believed that the disease had a nervous foundation. But it was also seen in cases that could not be described as neurasthenic, such for instance as children and new-born infants. Then fibrin was observed in the exudate, which pointed to an inflammatory origin, and by French authors especially the disease was looked upon as catarrh of the large intestine. There had been therefore two views as to the nature of the disease, the one that it was a nerve disease, the other that it was inflammatory. The speaker would attempt, on the basis of observation made in the Boas Klinik, to make the position clearer.

Only two cases were on record in which an autopsy was made; in one nothing was found, and in the other only a slightly inflamed mucous surface. The speaker was able to add two new cases. In the first case (which, by the bye, was hardly one to the point, as the condition was brought about by giving tannin injections) there was extensive casting off of epithelium, and slight superficial round-celled inflammation. The second case placed at his disposal by Professor Bender was one of pernicious *anæmia* with characteristic passing of mucous membrane. In this case in parts there was deposit on the mucous surface of what was probably epithelium, cast off *post mortem*. Besides this, there was a homogeneous mucin-like substance. In both cases, therefore, there was only slight inflammatory change. In the absence of marked inflammation therefore, it had been proposed to drop the term enteritis and to call the disease mucous colic or mucous neurosis, or myxoneurosis intestine. He himself would speak of the cases as mucous colic.

Looking at the clinical features, constipation must be looked upon as the chief cause, according to *Nothnagel* 80 per cent. of the cases. He himself had only seen mucus in twenty-eight cases out of sixty of constipation. Generally there was no pain when the membranes were passed. Simple colitis and membranaceous colitis could not be separated from one another. We could only recognise simple colitis as the sole catarrhal form of excretion of mucus, and in contrast to this the form originally known as mucous enteritis and which was known to depend on nervous causes. The latter disease mostly occurring in females, *Ewald's* myxoneurosis, was comparatively rare. Two forms of this were recognised, that in which the membrane appeared in distinct attacks, and that in which it was continuous. The disease was looked upon as a neurosis, and particularly because other nerve symptoms were almost always associated with it. As against this view, the speaker observed that obstinate constipation always preceded its onset by months and even years. The constipation caused the colitic changes in the bowel and these changes were certainly present in a portion of the cases before the excretion of mucus appeared. In favour of this also was the appearance of the mucus some time after the colic attack. Other differential diagnostic signs were of but little value, such as a difference in the composition of the mucous membranes, that in colitis the mucus was discharged along with the stool, but that on the other hand in the case of mucous neurosis it was discharged independently of feces.

The observations of *Mathieu* and *Westphalen* seemed of more importance, according to which cases

of membranous discharge were frequently associated with spastic constipation as was not infrequently observed in nervous people, and that this intestinal spasm was especially pronounced at the time of the attacks. The speaker's own cases confirmed the correctness of these observations. Such painful contractions especially when they were on the right side and there was also tenderness on pressure were frequently mistaken for symptoms of perityphlitis. *Kuttner* had described such cases as pseudo-appendicitis or pseudo-appendicitis nervosa. This form has even led to operative measures by the performance of which, however, the organs were found intact.

As regarded the cause of the hypersecretion we had nothing but hypothesis to turn to as we still knew but little regarding the innervation of the elements that secreted mucus in the intestines. Nervous secretion of mucus had never yet been brought about experimentally. The fact that many patients stated that the attacks of colic and the discharges of mucus came on frequently after psychological disturbances lent support to the view of the nervous origin of the disease.

At the Society of *Charité* Physicians, Hr. *Hoffmann* showed a case of

MYRAMINE EXANTHEM

that had come on after taking small doses of the drug. The rash, which was very irritating, and left pigmentation after it, came on on the face, thorax, the extremities, and the genital organs.

He also showed a case of isoform dermatitis, which came on a few hours after the application of a 3-per cent. isoform gauze applied after operation for phimosi.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, June 25th, 1905.

INOPERABLE CARCINOMA AND RONTGEN RAYS.

FREUND exhibited a patient to the "*Gesellschaft*," who came to him about the beginning of December with a carcinomatous tumour of the breast, too far advanced for operative purposes, on which he applied the Rontgen rays with wonderful success. When she saw him first the tumour was larger than a man's fist, of stony hardness, and firmly attached to the bony walls of the thorax. The surface of the tumour was ulcerated over the area of a five-shilling piece, while the axillary and subclavian glands were greatly enlarged.

On January 9th, after eight applications of the rays, there was intense reddening, associated with severe pain over the site of radial application. The swelling by this time had fallen to the size of an apple, with discharges of caseous matter, fever, and lowered appetite, while the neuralgic pains deprived the patient of a comfortable night's sleep. These pains were confined to the arm and mediastinum.

The rays were again applied between February 6th and 11th and March 6th and 10th. After February 18th the discharge began to change to a watery consistency with separating lamina; the swelling quite disappeared, and the edges of the wound subsequently became red and granular till it ultimately healed.

To-day a large cicatrix marks the site of the morbid growth. In the centre of this are a few excoriations about the size of pin-heads, but all the rest, which is about the size of the palm of the hand, is covered with healthy skin. The glands in the arm-pit and subclavium are decidedly less, while the patient is immensely improved. The pain is now more like a drawing of the cicatrix, but recently a bronchial catarrh has set in, which is probably due to pulmonary metastasis; otherwise the patient expresses herself as perfectly well again, and can enjoy herself.

SCLERODERMA.

Ehrmann next presented two cases of scleroderma to the members; one was of recent origin, the other was cured. He brought forward these cases to sustain the opinion which he expressed last year that sclero-

derma and atrophica cutis idiopathica were two distinct diseases, and separated by perfectly well differentiated clinical phenomena.

The latter has been demonstrated by Pick as a form of erythromelia and which has been proved by the microscope to be a perilymphangitis capillaris.

Scleroderma, on the other hand, is an acute hyperæmia, which can be seen around the plaques: not a congestion or stasis, but an arteria erythrodermia resulting from erythema in the diffuse form. He demonstrated this on the patients before him. The first, a female, æt. 40, had white spots about the size of two-shilling pieces on the arms and breasts surrounded by an intense red; in others the centre had a waxlike mass, hard and yellow, indicating the commencement of the cutaneous changes. Over the lower extremities and lower part of the body, where this diffuse rash existed, the patient suffered from a severe form of eczema and skin inflammation the year before, which had been treated by an experienced dermatologist, and no trace of scleroderma was observed. This case he contended, harmonised with his former reports on the subject which he has published where the scleroderma was preceded by universal erythema.

The second case, he said, belonged to the maculose form of the disease, and possessed a history similar to the other cases. A year ago the patient suffered from atony of the bowel, with ribbon-like stools, severe meteorism, difficulty of breathing at night, &c. Massage, gymnastics, diet, and aperients, was the treatment adopted, which produced the cure.

Ehrmann concluded by affirming that scleroderma was purely a case of auto-intoxication, and more frequently arose from the bowel although the glands might be the source of intoxication also. These, he contends, are opposed to erythromelia, which is a local idiopathic cutaneous atrophy, with clearly-defined symptoms differing from scleroderma.

SUPRARENAL EXTRACT.

Winter gave the members a history of this extract with its virtues and his own experience. Since 1896 when it was first brought before the profession, Königstein, Gottlieb and Furth have all borne testimony to its potency on the cardiac vessels and blood pressure, but Sherrington and Scroton, of Liverpool, added to its usefulness in 1903 by experimenting on the heart of a frog with $\frac{1}{2}$ per cent. solution of chloroform, which paralysed its action; after nine minutes the suprarenal extract restored it. With a $1\frac{1}{2}$ per cent. solution of chloroform on the heart of a cat the contractions ceased after nine minutes exposure; after sixty seconds pause the suprarenal extract was applied, and restored its activity. Winter gave a number of experiments of his own, which led him to use the extract for practical purposes where overdoses of chloroform were given. He tells us that he has restored the rhythmic action of the heart twelve to thirty-two minutes after the organ had ceased to move. He advises that in all cases of collapse from chloroform, artificial breathing should be kept up, while a solution of the extract should be driven directly into the left ventricle of the heart to restore it.

Thenen supported Winter's arguments and experiments by relating several of his own. By intradural cocaine injections shock is produced, and the vasomotor path of the cord suspended. After the shock has passed the vessels and heart remain weak owing to the lowered cardiac pressure. If the suprarenal extract be injected into the veins of patients whose blood pressure has been reduced to 35 millimetres of mercury, in ten to twenty minutes, nystagmus corneal reflex, closing of the eyelids, and sniffing, will herald the advent of the normal blood pressure, which soon after becomes steady and regular.

A BALL was given at the Wharnclyffe Rooms, Hotel Great Central, on June 20th, in aid of the Queen's Jubilee Hospital, Earls Court, which is greatly in need of funds. Nearly 500 people were present and dancing took place in rooms beautifully decorated with palms and flowers.

Operating Theatres.

ROYAL EAR HOSPITAL.

SUBMUCOUS RESECTION OF THE NASAL SEPTUM.—Mr. MACLEOD YEARSLEY operated on a man, æt. 33, who for the past two years had suffered from nasal obstruction with increased secretion. There was considerable expectoration in the morning, and he frequently complained of dry mouth and unpleasant taste on waking. He had been subject to catarrhal troubles for the past ten years, with frequent colds and fits of sneezing, but for the last two years he stated that he had never been free from a chronic cold. His voice was often very hoarse, and its production tiring, but there had never been any true aphonia. He had not suffered from deafness. On examination there was granular pharyngitis with some hypertrophy of the salpingo-pharyngeal folds. Laryngoscopy showed congestion of the lingual tonsil and laryngeal mucosa, the vocal cords moved well, but these were pinkish in colour and tended to stick together on approximation. There was also some tracheal congestion. Anterior rhinoscopy showed considerable oedema of the nasal mucous membrane; the septal tubercle was hypertrophied on both sides, and the oedema was so great that the middle turbinals could not be seen. After spraying with hemisine, a better view was obtained, although there was very little difference in the amount of obstruction, the septum being much deflected irregularly, so that both sides of the nose were blocked. The right middle turbinal was also much enlarged. Posterior rhinoscopy showed post-nasal catarrh, with some hypertrophy of the pharyngeal tonsil. The patient was placed under an anæsthetic by Mr. Chaldecott. After the nose had been well sprayed with adrenalin and a submucous injection of that drug made in the nasal septum, the right middle turbinal was removed with scissors and Doyen's forceps. An incision was then made through the whole length of the base of the septum on the right side, and the muco-periosteum completely dissected up with an Asche's separator. The cartilage having been completely detached from the floor of the nose the separator was used to raise it from the muco-periosteum of the other side; the whole of the cartilaginous septum was then removed piecemeal with Todd's forceps and the greater part of the bony septum was treated in the same manner. The left middle turbinal being also somewhat enlarged, was partially removed. The flap of muco-periosteum on the right side having been placed in position a moderate pad of adenoids was taken away, the operation being thus completed. Mr. Yearsley said that a large number of operations to rectify deflections of the nasal septum had been devised by various rhinologists and others, and each had its special application. The one he had just performed was probably the most radical, since it aimed at the almost complete removal of the rigid structures of the septum and the formation of a membranous partition in its place. When properly done it usually gave very satisfactory results, and, in his opinion, failure was nearly always due to not removing enough. Another advantage of this operation, he thought, was that the patient was able to breathe through the nose within a comparatively few hours of it, as there was no need of plugs or splints or packing. Some rhinologists advocated the fastening in position of the muco-periosteal flap with stitches, but in his experience there was no need of them whatever.

The patient left the hospital in a week, showing an excellent result of the operation.

TOTENHAM HOSPITAL.

OPERATION FOR DISEASED APPENDAGES.—Dr. ARTHUR GILES operated on a single woman, æt. 24, who had been sent to the hospital by Dr. Angus Hunt. The patient gave a history pointing to pelvic inflammation, and according to her own account was suffering from appendicitis; it was, however, evident from Dr. Hunt's account of the case, as well as from the physical signs, that appendages rather than the appendix were the seat of the trouble. There had been an attack of exanthorrhœa presumably of gonorrhœal origin, some two months previously. On examination a considerable swelling was felt on the left side of the uterus and a smaller swelling on the right. On opening the abdomen there were numerous light adhesions in the neighbourhood of the tubes; these were separated and the swelling on the left side was then found to consist of a thickened and occluded tube and an ovarian cyst. These were removed without any difficulty. On the right side the ovary appeared healthy. The abdominal ostium of the tube was occluded, but the tube itself presented only a slight degree of thickening, and it was therefore decided not to remove the right appendages, but to endeavour to restore the function of the tube by making an artificial opening (salpingostomy). This was done by making a longitudinal incision at the distal end of the tube, and passing one or two sutures of fine silk, so as to unite the peritoneum to the mucous membrane on each side of the incision. The abdominal wound was then closed up by the usual three-layer method. On opening the cyst removed from the left side, it proved to be an ovarian dermoid. Dr. Giles said that theoretically conservative procedure were the ideal ones in dealing with uterine appendages; but in practice it was sometimes found that conservative measures led to a continuance of symptoms and to repeated operations. This was especially the case when the adnexa were affected by gonorrhœa. Every now and then, however, a case occurred in which it appeared justifiable to adopt conservative treatment even with a gonorrhœal salpingitis. In the present case it was evident that the attack of salpingitis had been relatively mild; the tubes were not distended with pus, and there was no indication of grave infection of the surrounding structures. There seemed reason to hope, therefore, that if the right tube were left behind it would not set up fresh mischief in the pelvis, and as the patient was a young single woman of 24, it seemed worth while, when leaving the tube, to leave it with a possibility of active function. For this reason he had opened up its distal extremity, suturing the mucous membrane to the peritoneum so as to maintain the patency of the new ostium. The patient made an uninterrupted recovery.

It is reported that the late Baron Nathaniel Rothschild, of Vienna, left £850,000 to be devoted to the foundation of a sanatorium in the neighbourhood of Vienna for persons suffering from nervous affections other than epilepsy, insanity, and incurable spinal disease.

ONE of the most popular medical institutions in Glasgow is the Medical Golf Club. It was started three years ago, and the membership now numbers upwards of a hundred drawn from the medical men of Glasgow and the neighbourhood.

No less than fifteen van-loads of pulped fruit put up in barrels and tin cases were recently condemned by the sanitary inspectors of Stepney. The fruit was on the premises of the Eureka Preserving Company, Bow. It was in a decomposed and putrid state.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JUNE 28, 1905.

TUBERCULOSIS OF THE KIDNEY.

THE brilliant address of Dr. Howard Kelly, of Baltimore, delivered recently before the British Gynæcological Society, stands as a monument to the excellence of modern American surgery. In his own special branch of surgery Dr. Kelly has established a world-wide reputation. His operation of supra-vaginal hysterectomy, for instance, is performed daily all over the world, and he has contributed largely in other important ways to the science and the art of his speciality. In no department, however, has he achieved a sounder reputation than in that dealing with tuberculosis of the kidney, the subject chosen for his recent able and masterly address. Readers of the MEDICAL PRESS AND CIRCULAR may congratulate themselves upon the full report which, by reason of our close association with the society concerned we are privileged to give verbatim. They will find therein a graphic picture of the present position of medical science with regard to the diagnosis and the operative treatment of renal tuberculosis, with many illuminating side-flashes upon various more or less closely connected issues. It would be a task of supererogation in this place to attempt to discuss or analyse the material thus presented to our notice. At the same time there are many aspects of tuberculosis, even when it affects mainly or solely a single organ, that cannot fail to interest and concern medical practitioners in many diverse fields of practice. Henceforth, for instance, the consulting physician or the general practitioner in charge of a patient suffering from some tubercular affection will read urinary complications in another light. The difference between a hopeless and a curable condition is that between day and night. It is to the patient labours of many distinguished surgeons that we are indebted for the marvellous advances which

have brought the surgery of the kidney to its present pitch of perfection. In 1871, that is to say, thirty-four years ago, Simon extirpated the kidney and published his classical work on the subject. By slow degrees the true pathology and clinical history of the affection have been brought to light. In our own country the names of Knowsley Thornton, Morris, Newman of Glasgow, and Hurry Fenwick have become inseparably connected with this progress. Of much interest is the observation that this field of renal surgery was for a long time shut off from the surgeon by three serious errors. In the first place renal tuberculosis was seen by the pathologist only in cases of advanced or general tuberculosis, so that it was concluded the disease was either the local expression of a general condition or was invariably bilateral. Secondly, it was assumed that the disease of necessity involved more or less of the entire urogenital tract from its inception. Thirdly, it was further commonly assumed that the infection was of an ascending character and therefore ineradicable. The recognition of these errors has enabled the modern clinician to argue from sounder premises. To the average medical mind perhaps the most striking feature of the present position is the astonishing development of accurate diagnosis with regard to even the early stages of tuberculosis of so inaccessible an organ as the kidney. Bacteriology has been pressed into the service and in most instances where the disease is present is able sooner or later to afford positive evidence by demonstrating the specific pathogenic organism of tuberculosis in the urine. A remarkable illustration of the confident dogmatism of modern surgery is shown by the fact that the discovery of tubercle bacilli in the urine may impart an instant ray of hope into an otherwise hopeless case. But accurate diagnosis does not begin and end in the laboratory. By the aid of cystoscopy the surgeon is enabled to determine whether both kidneys are affected and if the disease be one-sided to say which kidney is the seat of disease. Nor is the progress of operative measures less remarkable and satisfactory. Dr. Kelly especially insisted upon the value of early and prompt nephrotomy. Without attempting to discuss the operative aspects of renal tuberculosis, attention may be drawn to a desperate and apparently hopeless case in which life was saved by a series of operations. The patient was emaciated, the bladder contracted, and the seat of an active universal cystitis. The first step was to make a large vesico-vaginal fistula. A tubercular kidney and thickened ureter were then removed and afterwards two portions of the bladder; the fistula closed, and the bladder irrigated and distended. Recovery in a case of this kind affords a striking illustration of the possibilities of modern renal surgery. The Gynæcological Society may be congratulated on having secured a distinguished contribution to the annals of contemporary surgery.

SPONTANEOUS GENERATION.

SENSATIONAL reports have lately appeared in contemporary journals. They relate that the origin of life has been at last discovered. With a wealth of ingenuity that only those ignorant of physical science could have brought to bear on the subject, the details of the discovery have been served up to tickle the palates of every class in the community from the crossing sweeper to the theologian. It is impossible for modern journalism to announce facts without embellishment, and equally impossible for it to observe a sane aspect of expectancy as to any consequences that may follow from the ascertainment of such facts. Indeed, it troubles itself little enough about the basis of fact at all, provided a good head-line or startling contents-bill may be rigged up. We are not old enough to remember the publication of the "Origin of Species," but we have failed to ascertain that that epoch-making book was accorded the dignity of the front page or leaded type by the journals of its day, and we are sure that Lister's work was not received with salvos of interviews and special reporters. The one great scientific discovery that received the attention of journalists early in its career, namely, Koch's tuberculin, has not yet recovered from the discredit which their premature and ill-advised "booming" conferred upon it. It is, therefore, with the desire to give Mr. Burke a fair hearing from the public that we deprecate most strongly the sensational stuff that has been filling the columns of newspapers for the last few days. If Mr. Burke's researches have revealed a method of producing living organisms from inanimate materials, they would have lost nothing in credit or stability if the knowledge of them had been confined to the Cavendish Laboratory and a select coterie of competent scientists for a year or two longer; if they merely indicate a new property of radium, any scientific value they possess will now be greatly discounted by the disappointment that will follow the demonstration of the nature of the bodies discovered; moreover, if there be any fallacy or error in the experiments, Mr. Burke will probably find his future career considerably hampered by these premature disclosures. The facts of the case seem surprisingly simple. Mr. Burke, who has been working for some years on the causes of the phosphorescence of cyanogen, turned his attention to similar properties which radium possesses in a higher degree than that body. In the course of this work he placed some radium in a test tube of sterilised broth, and was surprised to find in the course of a day or two that the broth contained certain microscopical bodies hitherto unknown. Sub-cultures of these bodies were made, and some slight multiplication was obtained, although the growth was far short of that which usually takes place when bacteria are cultivated. Moreover, traces of sub-division of the units were observed under the microscope. The fact that they are soluble in water would militate against

these bodies being living organisms, although it would not necessarily be fatal to such a supposition, whilst the other ascertained properties are all explicable upon the supposition that they are either crystals, or organic compounds existing in a state of unstable composition. The most that can be said of the bodies is that they are of an indeterminate nature, and that to elucidate and define their actual composition and full properties probably many months or years of patient work are needed. It is still fresh in the minds of medical men how cancer bodies were discovered, and even cultivated, and how this discovery has been discredited by the organised researches of those workers who, with sound scientific training and ample equipment, have lately taken up the investigation of the problems of cancer pathology. This memory is not sufficient to make scientific men sceptical as to the nature of all microscopical bodies, however startling that nature may appear to be, but it, and a hundred like it, make them chary of passing judgment till all the factors necessary to the formation of a judgment are to hand. The demonstration of spontaneous generation has long been the dream of scientific workers, and though the failures of the sixties and seventies damped the ardour of many, that demonstration is not to be regarded as impossible. It is, in fact, necessary to the full establishment of the evolutionary hypothesis of the cosmogony—this missing link in the transition between the inanimate and the animate. Whether the conditions for producing that transition are still capable of reconstruction, experiment alone can determine, but till spontaneous generation can be shown to occur a vital point in the evolutionary armour remains unguarded. The critical work of Pasteur, Tyndall, and others shattered the experiments of the army of spontaneous generators who knew neither bacteriology nor the composition of dust, and it is only reasonable to suppose that Mr. Burke's results may be found capable of another interpretation to that placed upon them at the moment when subjected, as they doubtless will be, to the searchlight of criticism from contemporary scientists and fuller knowledge of the properties of radium. We are not with those who regard the quest after spontaneous generation as hopeless as the search for the elixir vitæ or the philosopher's stone, but the scientific world will need evidence far more cogent than has yet been presented before it accepts Mr. Burke's experiments as even putting investigation on the right track. The immense interest attaching to the subject should make us particularly careful that desire does not outrun performance.

Notes on Current Topics.

A Hygienic Drinking-Fountain.

THE dissemination of specific diseases whose point of entry into the body is through the mouth and throat is favoured by many of the customs of

children. Licking slates is, or was, a favourite device among elementary school children, and the sucking of each other's toys, sweets, and even thumbs has always been favoured by them as a means of displaying amicable relationships. It is unfortunate that their elders have not given them a strong lead in the right direction, for in many instances the youngsters have been forced by the provision made for their wants to pass mouth organisms from one to another. Prominent among these provisions is the common drinking-cup attached to the fountains at which they quench their thirst. Without wishing children to indulge in either of the modes of imbibition favoured by the followers of Gideon it would seem clearly in accordance with the dictates of cleanliness that they should not be forced to drink out of a common cup. An ingenious means of circumventing the difficulty has been invented by a citizen of Rochester, U.S.A. This individual has constructed a drinking-fountain which consists of a marble pedestal three and a half feet high, approached by steps to suit the different heights of children of different ages, and furnished at its summit with a basin of the shape of an inverted cone. At the side is a stop, and when this is pressed upon, a small jet of water is shot up through the middle of the basin. In order to drink, the child has only to hold his head over the edge and receive the jet in the mouth. It is said that with very little practice a draught of water can be obtained as easily as by means of a cup, and by no possibility can the child soil any part of the apparatus with his lips. We commend the idea to school authorities and those charitable people who leave legacies for public drinking fountains.

Intestinal Toxæmia as a Predisposing Condition of Disease.

Most people, medical and lay, are aware of the hygienic importance of keeping the bowels clear. It is not only the surgeon, about to perform an operation, who insists on proper purgation, but the mother of a sick child pursues the same course, whatever be the illness from which the child is suffering. And it is noticeable that the homely dose of castor oil or Epsom salts, has excellent therapeutic effect, whether the illness be a threatened cold, a carbuncle, a quinsy, or any other infective condition. It is obvious that in these cases the morbid condition whose removal checks the progress of disease, must be some toxin of intestinal origin circulating in the blood. Adopting as a sign of the presence of faecal toxins in the blood the occurrence of an excess of indican in the urine, an American observer, Dr. Harris Houghton, of New York, has published (a) a series of cases showing a marked association between minor infections and faecal toxæmia. Of thirty consecutive cases of slight infection, such as carbuncles, boils, suppurative pimples, met with in private and hospital practice, he found marked indicanuria

(a) *Medical Records*, May 27th, 1905.

in no less than twenty-eight cases. In one case it was associated with glycosuria, while in one of the remaining cases glycosuria was present without indicanuria. If these figures are to be taken as fairly representative, then caution may suggest that certain steps further than the simple clearance of the bowels should be taken. Attention will have to be paid to diet, and it will be well when possible to avoid surgical operation while a patient is passing an excessive amount of indican in the urine.

Japanese Nursing.

To praise Japanese efficiency is to paint the lily. There seems to be no part of their public services that has not been raised in point both of organisation and of *personnel* to a pitch of perfection unknown in modern times. And all this has been brought about in the space of a few years. From all accounts the Japanese nurse seems to be able to give points to our home product in most details of the art. It is interesting therefore to note that in 1883 an American lady, Mrs. John Ballagh, being taken ill at Yokohama and wishing for the services of a trained nurse, was informed that such a thing was unheard of in the country. When sufficiently recovered, Mrs. Ballagh returned to her home in Philadelphia, and tried to raise money to establish a training school for nurses in Japan. Dying shortly afterwards, her wish was continued by a Mrs. True, who had been connected with the Presbyterian mission in Tokio. In 1885, sufficient funds having been obtained, a small school was opened and seven nurses received for training. The Charity Hospital was opened soon afterwards, and the authorities wanted nurses to staff it, but could not afford the attendant expense. The matter was taken up by a band of Japanese ladies, headed by the Empress herself, and another training class was established under a Miss Rud, of the Presbyterian Foreign Mission. To these small classes thus formed in 1885, modern nursing was taught by lectures and demonstrations, and in 1888 the first batch of native nurses graduated. Their example was quickly followed throughout the country, and nursing has now become as popular as other less desirable pursuits had been up to that time. To-day the Japanese nurse is second to none.

Hawaiian Fever.

As clinical observation and experimental research proceed, many of the local maladies formerly regarded as distinct entities take their places as forms of one or other of the commonly recognised diseases. There are still some, however, which defy this reduction, and of these one is the fever known in Hawaii by the local name. The Hawaiian Medical Association has recently been discussing the question of the fevers of the Islands; and the members have come to an agreement as to the existence of a distinct form of fever distinguishable from other clinical entities. In its general course and symptoms it most closely resembles typhoid

fever, but it is distinguished by its remarkably sudden onset, accompanied by rigors, and the absence of the typical typhoid course of temperature. Moreover, the blood is invariably negative to the agglutination test with the typhoid bacillus. It is believed not to be one of the malarial fevers, as apart from symptomatic differences, no organism has been detected in the blood, and anopheles has never been observed in the Islands. Quinine has no beneficial effect on the disease, and is regarded by some as distinctly harmful. Many observers are inclined to believe that the disease is in the literal sense "malarial" or miasmatic in origin, and it is said that an outbreak has been known to follow the turning up of the soil.

Chronic Acetanilid Poisoning.

The general use into which the coal-tar products have come of late years has fortunately been attended with but few unfavourable results. It is, however, inconceivable that these valuable drugs do not cause more or less harm when taken habitually and in the absence of medical supervision. Nowadays the names of most of these products are household words, and many women when they have a headache or an attack of neuralgia instead of consulting a doctor, have recourse to the chemist or stores or a tin of antipyrin or a bottle of phenacetin tablets. How far some of the ill-defined conditions of bad health that are met with are due to this pernicious habit is an interesting but difficult question to decide. In the *Journal of the American Medical Association* for June 3rd, Dr. D. D. Stewart relates two cases of chronic poisoning by acetanilid in persons who were accustomed to take that drug. The chief symptoms were cyanosis, cardiac debility, and blood changes associated with hæmolytic. Thus the erythrocytes were diminished in number and altered in size and shape, while erythroblasts and poly-chromatophilic cells were present, together with cells undergoing granular degeneration. Leucocytosis has been noted in many such cases, but in those cited the lymphocytes numbered thirty-seven and thirty-five per cent. respectively. The blood-plaques were markedly increased. It is well to bear in mind that though the danger of acute poisoning by acetanilid is now greatly diminished, the possibility of chronic poisoning remains.

Hospital Reform in New Zealand.

It is not merely in these countries that the question of hospital abuse has become a pressing one. In New Zealand it appears that as the hospitals are financed by the State, there is little compunction on the part of many well-to-do people in making use of hospital treatment, and at the same time of the gratuitous services of the medical men attached. The evil has become very grave, and the medical men of the colony will find it necessary to take some steps to prevent its further growth. Moreover, it appears that while

a hospital board can recover from a well-to-do patient the cost of his maintenance and nursing, it is impossible for the medical man to obtain any fee for his services. This condition is, however, only one of a number of abuses under which the New Zealand hospitals suffer, nor does there appear to be any easy means of remedying them without a radical reform of the whole hospital system. The management of each hospital is under the control of a locally elected board, without any representation of the honorary staff. As the finances are nearly entirely supplied by Government, and only in small degree by local aid, it follows that the board is administering funds not its own, and as is natural there is a certain degree of lack of responsibility. It is suggested by Dr. Robertson (*a*) and responsible medical men that the present boards should be replaced by others in whose appointment the Government should have a preponderating voice, and in which the honorary medical staffs should possess a certain number of seats. It is thought that under such a system much could be done in a practical way to remedy the evils which are known to exist at present.

American Voice.

OUR American friends are always sensitive on the subject of their voices. The man from New York or Boston always explains that even if he speaks with a slight intonation, it is as nothing compared with the twang prevalent in San Francisco; while the San Franciscan adopts a similar attitude with regard to the New Yorker. The Bostonian's ears are terribly hurt by the grating voice of the inhabitant of Florida, while the Floridan is no less offended by the squeaky pitch at which the Bostonian conducts his conversation. To the average Englishman, all Americans seem to speak more or less "through the nose," but he has to be careful not to express such an opinion if he values the regard of his acquaintances from over the Atlantic. At the Section of Laryngology and Rhinology of the New York Academy of Medicine the other day, a discussion took place on the "Pathology and Treatment of Non-malignant Growths of the Larynx," at which one of the speakers attributed the frequency of laryngeal neoplasms in France to the national habit of speaking a *haute voix*. A later speaker following, the same line of argument, said that benign laryngeal growths in America were less common than they were ten or fifteen years ago. This fact he attributed to the improvement in the use of the speaking voice and to the greater attention paid to nasal hygiene than formerly. The "Awful American Voice," of which so much had been said, was not so common as formerly. This high-pitched screaming was a fruitful source of laryngeal irritation, and led to thickening of the cords, and later to the production of fibromatous papillomata. It is a matter for satisfaction in these days, when American importations of all kinds are said to be ruining our home industries,

(a) *New Zealand Med. Journ.*, April 6th, 1905.

that we have been able to return good for evil by teaching our competitors how to use the speaking voice, and thereby reducing the prevalence of such uncomfortable and dangerous maladies as laryngeal neoplasms.

Regulations of Patent Medicines.

IN the matter of paying attention to the public welfare, there are many points on which the mother country might learn from the Colonies. One of these is the regulation of the sale of proprietary drugs, poisonous and otherwise. We learn, for instance, that by a regulation recently promulgated by the Governor of New Zealand it has been commanded that no person shall sell or offer to sell any patent medicine within the Colony until a full statement has been deposited with the Minister of Public Health, showing the several ingredients contained in such patent medicine, and the quantity or proportion of such ingredients. At first it was proposed to make it compulsory to publish the composition on the label, but owing to the opposition of certain manufacturing firms this intention was abandoned. It is, of course, a pity that the more stringent regulation was not allowed to stand, but nevertheless the one we have quoted should of itself have good effect. Moreover, it is ordered that the label of every patent medicine containing poison shall be distinctly marked with words stating that fact. The penalty for breach of either regulation is a fine not exceeding £50.

Consumption and Travel.

ATTENTION has been called at various times during the past few years in our columns and elsewhere to the dangers ensuing to the public from the use of travelling conveyances by sick people without due precautions. In particular we have emphasised the risk of the spread of typhoid infection by the present haphazard method of disposing of excrement on railway journeys. A more obvious, as well as a more wide-spread danger, is that of the diffusion of tuberculous disease by expectoration in railway carriages. Though it is true that most railway companies post in more or less conspicuous places notices forbidding spitting on the floor or elsewhere, very few, however, in these countries, at any rate, take any trouble to enforce the regulation. In third class carriages on many of the local and branch lines passengers would almost need to wear top boots in order to protect themselves from the filth which is allowed to collect on the floor, and from the violent expectorations of their fellows. The condition of many of these carriages is an outrage not merely on our sense of decency, but on all hygienic observance. In a safeguard against persistence of dust in railway and other public carriages, it would be well if the use of leather or some smooth upholstery were substituted for the pervious materials at present in common use, though, of course, such a change would be in itself useless unless proper cleansing methods were employed. It is the duty

of the medical profession by preaching in season and out of season, to impress on the public the necessity of adopting such simple safeguards as cleanliness and decency would of themselves command.

Insane Persons as Witnesses.

A CASE of peculiar medico-legal interest is reported from the State of New Jersey. It appears that certain attendants in the Essex County Asylum in that State were put on trial on the charge of murder of a patient in their care, the only evidence against them being that given by other insane patients. The patient who met his death had attacked one of the attendants, stabbing him with a fork, and in the struggle which ensued before he was secured in a straight jacket, he succeeded in biting off the ear of another. The evidence of three insane patients who witnessed the occurrence was that the attendants returned after a considerable interval of time, and beat the lunatic with a baseball bat, finally killing him by pounding his head on the floor. Their story was filled in with details so revolting and astounding as to have rendered the tale incredible to the jury, who promptly acquitted the prisoners. The case is probably unique in that there was no other evidence for the prosecution than that of insane persons. It is, however, a curious instance of the inconsistency of lawyers that they permit to appear as witnesses persons who, no matter what evidence they might give, could not be put on their trial for perjury. Insane persons are often, as in this case, capable of entering upon a conspiracy of the most dangerous character, and if their evidence is to be received, there is an end to the security of asylum physicians or attendants from the most serious and damaging charges.

County Council Steamer Service.

It is to be hoped that the next generation of Londoners will find the city bequeathed to them a cleaner, brighter, and healthier place than their immediate ancestors found it. Already it is difficult for some of those still living to realise the conditions under which they lived, moved, and had their being twenty or twenty-five years ago. In nothing, perhaps, will the children of the present race of men find more to wonder at and to be thankful for than in the improvements in methods of transit between one part of London and another. The stuffy, evil-smelling bus has already given way to a clean, fairly well ventilated vehicle, in which it is possible to sit for half an hour without being nauseated; the vile, sulphurous atmosphere of the Underground is likely soon to be replaced by air that is respirable; and, best of all, the natural highway of London is to be utilised by modern steamers to convey workers to and from their daily work. The gain to health, to say nothing of comfort, which will result from passengers being able to breathe pure fresh air on their journeys to the City is inestimable, and it may be safely anticipated that their capacity

for good and clear work during the day will be substantially greater than if they had arrived at their destination half-choked with sulphur and carbon. No more enlightened task could be undertaken by a health authority than that of providing cheap, cheerful, and hygienic methods of transit for the workers of a great city.

Birth Announcements and Limitation of Family.

FOR many years past commercial activity has displayed a never-resting vigilance in its search for fresh outlets. This enterprise is, on the whole, innocent enough, however obtrusive and annoying to the recipients. Of this type is the manufacturer of infant's food or of baby rattles, who sends an advertisement of his wares to the fond parents whose increase of family is published in the births column of a newspaper. Sometimes, however, the pushing tradesman becomes offensive in his attentions. A correspondent has sent to us a letter recently addressed to the parents mentioned in a birth announcement. It hails from a maker of surgical rubber goods, who introduces his wares with an allusion to the necessity and importance of "limitation of family," and states that he has established a postal department for the convenience of customers residing at a distance. The individual or persons issuing this circular letter trade under the name of Thomas Gill and Co., of Newgate Street, London. Their methods seem to us to be sailing dangerously near the wind.

Proposed Meeting of the British Science Association in Dublin.

A VERY influential and thoroughly representative meeting was held on Friday last in the Mansion House, Dublin, to consider the advisability of inviting the British Association for the Advancement of Science to meet in Dublin in 1907. A number of prominent men, including the Lord Mayor, the Provost of Trinity College, Rev. William Delany, Sir Horace Plunkett, the President of the Royal College of Surgeons and Sir Christopher Nixon spoke, and with really wonderful unanimity it was decided that the Association should be invited to Dublin, and that the Universities, the Royal Dublin Society, and other public bodies should vie in welcoming it. On the motion of Sir Horace Plunkett, it was decided to form a Committee, with power to add to its number, to carry out the necessary arrangements for the meeting. The meeting was also of opinion that the Association would almost certainly accept the invitation. The proposed meeting, if held, will be the fourth meeting of the Association in Dublin. The first was in the year 1833, the second in 1857 and the last in 1878. It is thus quite time that another meeting should be held there. It will be necessary to raise a guarantee fund of about three thousand pounds, but this will prove an easy matter. As a contemporary points out, at the last Belfast meeting of the Association Professor

Tyndall discussed the origin of life, and now, on the eve of the proposal⁷ to hold another meeting in Ireland, comes the announcement from the Cavendish Laboratories, Cambridge, that Mr. John Butler Burke, a former student of Trinity College, Dublin, has succeeded in producing in sterilised broth, by the action of radium, bodies which from their mode of division appear to possess the characteristics of micro-organisms. What may be the outcome of Mr. Burke's experiments cannot yet be foretold, but it will presumably be a considerable time before it will be possible to make a definite statement as to the real nature of these appearances. Even, however, supposing that they are proved to be micro-organisms, would it not be more reasonable to think that Mr. Burke's experiments had resulted in the discovery of a variety of ultra-microscopic organisms capable of resisting the usual modes of sterilisation and capable of developing to microscopic size under the stimulation he applied, than to think that "life" had been created?

Celery and Cheese.

It has been remarked that the pursuit of health is mainly accomplished by giving things up one after another. First go stimulating beverages, then tobacco, then the more innocent articles of diet, until finally the hapless individual, still firmly believing that the goddess of health is showering favours upon him, is left with only the barest necessities of existence. Even the last-mentioned are cheerfully resigned by the ardent health-seeker of to-day. The whole question is one which centres around food and dietetic considerations. Never was there such a time as the present for the flourishing of so many different "cults" in the matter of diet. Some of them are of a mushroom character, while others seem to have established a more or less permanent footing in our midst. At the annual dinner of the London Vegetarian Association, there was ample provision made for diners of all shades of vegetarian opinion, for uniformity is no less rare in vegetarianism than in other beliefs. Those who would have nothing to do with cheese did not disdain its gentler concomitant of celery, while those to whom white bread is a stumbling-block and an offence went so far as to bring whole-meal bread with them. We do not know whether pickles figure largely in a menu of this sort, but there can be no doubt that it is almost as harmful to consume a considerable amount of condiments as to indulge moderately in food-stuffs known to contain purin bodies. Occasional abstinence from flesh never does anybody harm, but serious mischief may result from a mistaken idea, unfortunately only too common, that pickles and similar hot or acid substances are good for the blood. The British workman knows, from long experience, that good bread and cheese can hardly be equalled as an economical and satisfying food, and in this respect he is undoubtedly right.

A GARDEN-PARTY will be held on Tuesday July 4th, from 3 to 6.30 p.m. in the grounds of the new country branch, at Northwood, of the Mount Vernon Hospital for Consumption and Diseases of the Chest. H.R.H. the Princess Christian will be present. The dedication of the Hospital chapel will also take place, conducted by the Right Rev. the Bishop of Islington. There is a good service of trains from Baker Street Station to Northwood.

A MOST successful gathering of Metropolitan and provincial members of the Neurological Society of the United Kingdom was held at the National Hospital, Queen's Square, on Saturday, June 24th. There was an excellent museum, and the demonstrations on clinical cases and pathological specimens aroused much interest. Lunch was served at the Hotel Russell, and dinner was held at Oddenino's Imperial Restaurant. Enjoyment and instruction were admirably blended in the day's proceedings.

PERSONAL.

THE Duchess of Albany will visit Cobham to-morrow 29th inst., to open a new cottage hospital.

AMONGST those who are to receive honorary degrees at the forthcoming commencements at Dublin on July 6th are Sir Richard Douglas Powell, Bart., Mr. H. R. Swanzy, Professor E. A. Schäfer, and Professor Sydney Young. The two former receive the degree of M.D., the two latter the degree of Sc.D.

DR. CHARLES O'REILLY has resigned the position of Medical Superintendent of the Toronto General Hospital, a position which he has held for almost thirty years.

THE annual prize-giving of the London (Royal Free Hospital) School of Medicine for Women will take place on Thursday next, June 29th, at 4 p.m., when Mr. H. T. Butlin will present the prizes.

AT the Meeting of the University Court, Edinburgh, on June 12th, an application was received from Dr. A. R. Simpson Professor of Midwifery and Clinical Surgery for permission to retire from the chair as at August 31st next. Professor Simpson has occupied the chair for over thirty years.

SIR JOHN GORST, M.P., will distribute the prizes to the students of St. Mary's Hospital Medical School, and Mr. H. T. Butlin those gained by the students of the London School of Medicine for Women.

MR. TWEEDY, President of the Royal College of Surgeons of England, will distribute the prizes at Westminster Hospital Medical School on Thursday at 4 p.m., and will deliver an address at 4.30 p.m. on the same day.

THE Rev. James Gow, Litt.D., Head Master of Westminster School, will distribute the prizes and certificates at King's College, London, on Wednesday, July 25th, at 3 p.m.

SIR R. DOUGLAS POWELL, BART., recently delivered the annual Bolingbroke Lecture in connection with the South West London Medical Society. His subject was "Some Clinical Lessons from the History of Medicine in the Last Half-Century."

DR. G. E. J. Greene has declined to go forward a Irish candidate on the General Medical Council. Up to the present all the candidates in the field are Sir W. Thomson (Dublin), Dr. L. Kidd (Enniskillen), and Dr. R. B. Mahon (Ballinrobe).

THE Epidemiological Society of London will celebrate the fifty-fifth anniversary of its foundation on Friday, June 30th, when the annual dinner will take place at the Grand Hotel, Trafalgar Square, London, at 7.15 p.m. The President, Dr. B. A. Whitelegge, C.B., his Majesty's Chief Inspector of Factories, will take the chair.

THE Right Hon. Lord Ludlow has promised to distribute the prizes to the students of St. Bartholomew's Hospital and College, in the Great Hall of the Hospital, at 3.30 p.m. on Wednesday, July 12th.

WE understand that Sir J. Batty Tuke intends this week to present Bills to the House of Commons to prevent joint stock companies from carrying on the practice of dentists, except by legally-qualified persons, and to prohibit such companies from acting as physicians, surgeons or medical practitioners.

Special Articles.

THE QUATERCENTENARY OF THE ROYAL COLLEGE OF SURGEONS.

THE preparations for the festival which the College is about to hold on the 19th, 20th, and 21st of July, in celebration of the four-hundredth anniversary of its incorporation are now well advanced, and the functions promise to be worthy of so interesting an historic occasion. The chief event will be the commemoration ceremony in the MacEwan Hall, at which an address will be delivered by the president, and a number of honorary fellowships will be conferred by the College, which, in its turn, will receive congratulatory addresses from many learned and scientific societies and incorporations. The following is the list of those who are to be admitted Honorary Fellows:—H. M. Ellis, Director-General of the Navy Medical Department; A. Keogh, Director-General of the Army Medical Department; the Director-General of the Indian Medical Service; the President of the Royal College of Surgeons of England; Arthur Chance, President of the Royal College of Surgeons of Ireland; H. E. Clark, C.M.G., President of the Faculty of Physicians and Surgeons of Glasgow; John Playfair, President of the Royal College of Physicians of Edinburgh; Lord Lister; Professor Lucas Champonniere, Paris; Prof. Paul Legond, Hopital Salpêtriere, Paris; Prof. Guyon, Hopital Necker, Paris; Prof. Francesco Durante, Professor of Clinical Surgery; University of Rome; Prof. Czerny, Heidelberg; Prof. E. von Bymann, Berlin; Prof. König, Berlin; Prof. E. Fuchs, Professor of Ophthalmology, Vienna; Prof. Kronlein, Zurich; Prof. Gustav Lennander, Upsala; Prof. Saxtorph, Copenhagen; Prof. Halsted, Johns Hopkins Hospital; Prof. W. W. Keen, Jefferson Medical College, Philadelphia; Prof. J. C. Warren, Harvard Medical School; Charles McBurney, New York; W. J. Mayo, Rochester, Minnesota, U.S.A.; Prof. Shepherd, McGill College, Montreal; Prof. Cameron, Toronto; Dr. Fitzgerald, Melbourne; Dr. McCormack, Sydney; Baron Yasuzumi Saneyoshi, Director-General Imperial Japanese Navy, Tokyo; Prof. Anton von Eiselsberg, Vienna; Prof. Poncet, Lyons; Prof. Terrier, Paris; Prof. Subbotin, Petersburg; Prof. Bier, Bonn; and Prof. Bruno Krojius, Finland. Among other functions there will be a service in St. Giles' Cathedral, an evening reception in the Royal College of Surgeons, and a garden party. A banquet will be given by the College of Surgeons, and a luncheon by the College of Physicians.

The actual anniversary falls on July 1st, the date of the "Seal of Cause" granted in 1505 by the Town Council to the Barber-surgeons of the City and liberties

of Edinburgh, which erected them into a trades guild, with the monopoly of the barbers' and surgeons' craft, the privilege of obtaining the body of "ane condemnit man efter he be deid" to make anatomy of, and the sole right of making and selling aqua vitæ within the burgh. The surgeons thus early enjoyed the protection of the town; their deacon or president was *ex-officio* a member of the Council, and as that body had the right of returning the two Edinburgh members to the Scots Parliament, it is not surprising to learn that more than one deacon of the surgeons represented the town in the legislative Chamber. Like other similar incorporations, the surgeons gradually separated themselves from the barbers, and after the first hundred years of its existence the company of barber-surgeons treated the simple barbers as mere dependents, admitting them only to "cow (bruns), clip, scharpe, and wesche," but to use "na point of chirurgie" whatsoever. A legal connection between the two employments, however, subsisted until 1722, when they were severed from one another by a decree of the Court of Session. A body which had honourably acquired and justly exercised a practical monopoly of the profession of medicine naturally resented any infringement of its prerogatives, hence it is not surprising to learn that the surgeons along with their supporters, the Town Council, and the Bishops as Chancellors of the Scotch University, on several occasions frustrated the efforts of the physicians to obtain a Charter; in 1657 they were so greatly alarmed by the provisions of a patent in favour of the physicians which was just about to receive Cromwell's signature that they combined themselves with the Apothecaries the better to defeat it. The Incorporation of Surgeon-Apothecaries, however, after a somewhat stormy existence of some forty years, took its feuds into the Law Courts, with the result that the Judges decided that the two professions were distinct from each other and ought not to be united. Immediately before this dispute was settled, the surgeons secured in 1695 an important extension of their power by a Patent from William and Mary, erecting them to a college (subsequently made a Royal College by George III. in 1778) and widening their jurisdiction over practitioners of surgery from the limits of Edinburgh to the whole of the South-Eastern Counties of Scotland. This increase of their power naturally created a greater demand for medical teaching in Edinburgh, and thus led indirectly to the foundation of the Edinburgh Medical School, the pioneers of which, John Monro, his son Alex. Monro primus, and Archibald Pitcairn, became Fellows of the College in the early part of the eighteenth century.

A few years before the surgeons got their Royal Patent, the physicians had in 1681 procured a Charter, and the two bodies, despite a certain amount of hostility in respect of infringement of the physicians' right by surgeons and *vice versa*, which soon, however, was suspended as wiser counsels prevailed among them, and more important objects arose to occupy their attention, devoted their energies to founding a proper seminary of medicine from which the medical faculty of the University as well as the extramural school developed. It cannot be too clearly stated that the Faculty of Medicine within the University was thrust on it from without, and that it arose by the "Towns College" nominating as Professors members of the two incorporations who were in many cases at least recognised as lecturers by their colleges before the University took any cognizance of the subjects they taught. The first stride in medical education was made in 1694, when Alex. Monteith petitioned the Town Council for anatomical subjects; and the surgeons awakened to the importance of the step taken by one of their number obtained a similar grant, on condition of building an anatomical theatre. In 1705 special teachers of anatomy were appointed by the College, and at the same time the Town Council, as patrons of the University, gave the title of Professor to the College's nominee. After one or two changes the celebrated Monro primus held this chair, and did

much for the prosperity of the medical school. The original Hall of the College was built on ground belonging to the Black Friars, just inside the city wall; it has long been demolished, but their second house, built to accommodate the anatomical theatre, still exists as a part of the old Royal Infirmary, which bought it as a part of its extension scheme of the early part of last century. Their buildings are now being reconstructed to serve as a Physical Laboratory for the University. In consequence of their hall being required by the Infirmary, the present College of Surgeons was built in 1832, and now houses the magnificent pathological and anatomical collection, whose treasures are too little known to the students of today. For four hundred years the College of Surgeons has assiduously striven to regulate medical practice; in its earliest days it suppressed unlicensed quacks, ignorant persons, and impostors; it seems never to have admitted members within its own portals save after sufficient examination, and after the passage of the Medical Act of 1858 it co-operated with the sister College to grant a double qualification in medicine and surgery. It founded a great medical school—in its zenith the most renowned in Europe, and the brightest stars of that school have adorned its presidential chair. A record, this, of which the College may well be proud, and which well deserves all the honour which the coming celebrations can throw on it.

ROYAL INSTITUTE OF PUBLIC HEALTH.

THE following is the programme of the London Congress to be held from Wednesday, July 19th, to Tuesday, July 25th, 1905, of which the Most Honourable the Marquis of Londonderry, K.G., is President; Professor W. R. Smith, M.D., F.R.S., being President of the Institute; and Mr. James Cantlie, M.B., F.R.C.S., Hon. Secretary of the Reception Committee.

On Tuesday, July 18th, the reception-room opened at the Polytechnic, Regent Street, will be open for tickets and invitation cards.

Wednesday, July 19th.—3 p.m., inaugural meeting and opening of the exhibition at his Majesty's Theatre, Haymarket; inaugural address by the President, the Marquis of Londonderry, K.G. 8 p.m., evening fete at the Gardens of the Royal Botanic Society.

Thursday, July 20th.—10 a.m. to 4 p.m., sectional meetings. 3.30 p.m., a garden party in Russell Square Gardens, by the president and Council of the Royal Institute of Public Health; in connection with this demonstrations will be given in the chemical, bacteriological and pathological laboratories of the Royal Institute, 37, Russell Square. 7 p.m., the Congress dinner at the Hotel Cecil, at which the Right Hon. the Marquis of Londonderry K.G., will preside. Ladies will be admitted, and the dinner will be followed by a dance; an early application for tickets is requested, the price of which will be one guinea (inclusive).

Friday, July 21st.—10 to 4 p.m., sectional meetings. 3.30 p.m., garden party at Normansfield, Hampton Wick, at the invitation of Dr. R. Langdon Down. 3.30 p.m., garden party at Madame Bergmann Osterberg's Physical Training College, Dartford Heath, Kent, at which demonstrations of rational and irrational gymnastic systems, dancing, &c., will be given. 7 p.m., dinner by the Worshipful Company of Carpenters.

Saturday, July 22nd.—Excursions will be arranged: (1) To Henley by train, reception by the Mayor and Corporation of Henley, thence by steam launch to Medmenham Abbey, where luncheon will be provided, and thence by steam launch to Maidenhead, where the members will be received at a garden party at Taplow Court by W. H. Grenfell, Esq., M.P., D.L., Chairman of the Thames Conservancy Board. (2) To Windsor by steam launch from Hampton Court, where luncheon will be provided. The apartments at Windsor Castle will then be visited by the gracious permission of his Majesty the King, Patron of the Royal Institute. Facilities have been granted, through the kindness of the Provost of Eton, for the members

and delegates to visit Eton College. Tea will be subsequently provided by the kind permission of the Mayor and Corporation in the Guild Hall, Windsor. (3) An excursion to the First Garden City at Letchworth, where luncheon will be provided by the kindness of the directors; afterwards the party will proceed to Hatfield House, by the kind permission of the Most Hon. the Marquis of Salisbury, C.B., Lord Privy Seal, President of the Board of Trade. Early application must be made for those various excursions, as the numbers for each are necessarily limited.

Sunday, July 23rd.—(1) Special service at St. Paul's Cathedral at 9.45 a.m. The sermon will be preached by the Right Hon. and Right Rev. the Lord Bishop of London, D.D. (2) Special service at the Roman Catholic Cathedral, Westminster, at 11 a.m. The sermon will be preached by his Grace the Archbishop of Westminster. (3) Special service at the City Temple, Holborn Viaduct, at 11 a.m. The sermon will be preached by the Rev. R. J. Campbell, M.A. (4) In the evening, at 7 p.m., a service will be held in Westminster Abbey. The sermon will be preached by the Right Rev. the Lord Bishop of Birmingham, D.D. (5) At 7 p.m. a special service will be held in connection with the Congress at the Southwark Cathedral. The sermon will be preached by the Right Rev. the Lord Bishop of Hereford, D.D.

Monday, July 24th.—10 to 4 p.m., sectional meetings. 4 p.m., garden party at Sudbury Park, Wembley, at the invitation of Mr. and Mrs. Titus Barham, when the farm, milk laboratories, and dairies of the Walker-Gordon Laboratories will be inspected. 8 p.m., reception at the Mansion House by the Right Hon. the Lord Mayor of London.

On Tuesday, July 25th, the closing meeting will be held at 12.30 p.m.

Arrangements have been made with the principal railway companies in the United Kingdom by means of which special return tickets will be issued to delegates to the Congress at a fare and a quarter. The tickets will be obtained on application to the Secretary, the Polytechnic, Regent Street, London.

By the kindness of the Aylesbury Dairy Company, delegates will be enabled to inspect the laboratories pasteurising plant, &c., at the Company's Depot at St. Petersburg Place, on presentation of their Congress ticket.

Membership of the Congress can be obtained by any person interested in the work. Subscription, one guinea. Ladies accompanying members or delegates, 10s. 6d. each.

Special Correspondence.

[FROM OUR OWN CORRESPONDENT.]

SCOTLAND.

REPORT ON LUNACY IN SCOTLAND.—The General Board of Commissioners in Lunacy for Scotland recently presented their forty-seventh annual report regarding the state of lunacy in Scotland. This report being the fifth in a quinquennium, they compare this period just finished with former periods of five years. The Commissioners refer in their report to the following facts:—The number of patients in the asylums has largely increased both in actual numbers and proportionally as regards the population. The increase of residents in private asylums has been small, but in the public asylums it has been very great, and has risen steadily during the past ten years. This increase does not refer in particular to any special district, but has been observed in all districts alike. The number of admissions to these public asylums in the year has also increased, the increase being steady during the last thirty years. These increases, however, are absolute; the increase of admissions per year, taken in proportion to population, has been very small, and has been only seen in certain districts, other districts showing a decrease. The large increase in the number of patients resident in asylums as compared

with the much smaller increase, and in some districts a decrease even, in the number of admissions, can only be explained by the fact that there has been a decrease in the number of discharges during the past five years. There seems to be no particular cause, as regards the country as a whole, to account for this decline; in some cases it is within local control, and in others the local authorities are quite free of responsibility. There is a great need, however, of the matter being looked into, and also the utmost necessity for those authorities finding themselves responsible to try to effect a cure. As regards the death-rate, the Commissioners say in their report that there has been an increase during the last fifteen years in the number of deaths in crowded districts. There has been no increase in the number of admissions to private asylums, nor has there been any increase during the last five years of the number of those admitted to pauper asylums for the first time.

PROPOSED REFORM IN THE UNIVERSITY.—Several years ago it was proposed to divide the University year into three terms instead of two, a summer and a winter term, as at present. This proposal has been before the University Courts several times during the intervening period, but other business has kept it hidden so far. However, a conference took place at Glasgow University a few days ago, when there were present delegates from the four Scottish Universities. The subject was thoroughly discussed, but, of course, privately. It is understood, however, that the feeling of the meeting was in favour of the scheme. The scheme proposed is that there should be three terms, of ten weeks each, in the year. This would, of course, cause a curtailment of the long summer holiday, but this most likely will not be seriously objected to by the students who wish to work—surely the larger number. This scheme will also be popular with the professors who have the welfare of the students at heart—all of them it is hoped. It is thought that the results of the conference will be known in a few weeks after the delegates have given in their reports to their various Universities. If the result is favourable to the scheme, further developments may be looked for. Hindrances there will be, but these are not expected to be so great as to cause the overthrow of the proposal, in view of the fact that it is generally allowed that it would be to the benefit of the students to have such a scheme in operation.

BELFAST.

LURGAN WORKHOUSE SCANDAL.—The local papers have had long accounts daily of the Local Government Board inquiry into an unfortunate business at Lurgan. It arose out of the removal of a child suffering from small-pox from Portadown to the fever hospital at Lurgan Union. The child, who was seemingly unvaccinated, died, and the parents blame the Lurgan officials, medical and lay, for general neglect and carelessness. The statements made at the inquiry have been most contradictory, but there is little doubt at any rate that the child was very ill when moved, that the ambulance was a wretched old trap like a bread-cart, and that the ward in which the child and its mother were put was dark and dirty, no proper preparations having been made. The medical officer, Dr. Darling, has the sincere sympathy of his many friends, as he seems to have been involved by the carelessness of others, and then misled by their erroneous statements.

A NOVEL DIFFICULTY.—Dr. Watson, of Limavady, has been giving evidence before the magistrates as to a rather novel difficulty in which he has been placed. It appears that his house is in the main street of the town, and in that street markets and fairs are held, and cattle wander over the footpaths and even into the doors occasionally. The nuisance has become so great that a prosecution was instituted, and Dr. Watson stated that on the previous day he was actually unable to leave his house, the door being blocked by a herd of fifty or sixty cattle. The defence of the owners was that this had been the custom for so many

years that they had a prescriptive right to sell their cattle there. A small fine was imposed and a case stated. The matter is of interest to the inhabitants of many small towns and villages in Ireland, where similar customs prevail.

THE BELFAST GUARDIANS AND THEIR CONSUMPTIVE SANATORIUM.—An interesting correspondence is going on between the Guardians and the Local Government Board concerning the Abbey Sanatorium, in which forty consumptives are now lodged. The Belfast Workhouse and Infirmary are greatly overcrowded, and the Local Government Board gave their consent to the laying out and opening of the Sanatorium, on the understanding that all the Belfast Union consumptives were to be removed to it, leaving more room for other cases. This is not the view of the Guardians, however, for they are anxious to keep the Sanatorium for incipient cases only, which offer a prospect of cure. Under ordinary circumstances such cases would not go near the workhouse infirmary, and clearly the Guardians will have to go into the highways and byways and compel them to come in, that their Sanatorium may be full, and thus score a point over the City Corporation, which is still debating the question of a Municipal Sanatorium. It is no doubt a laudable ambition to wish to treat these early cases, but considering the record of the Guardians in the past it is not surprising that there should be some misgivings in the minds of the public as to the fitness of such a body to carry out such an important undertaking. And, of course, if the Guardians are allowed to do as they wish in the matter, they entirely fail to attain the end for which the Abbey was leased, that is, the relief of the congested state of the workhouse.

SMALL-POX IN BELFAST.—After some months' freedom from small-pox, another case has occurred in the city, and so far the source of infection has not been traced. It is just four months since the last case was removed to hospital. This patient is a working man, who has not been out of Belfast for several months. The case is a severe one.

Correspondence.

THE ADMINISTRATION OF THE MIDWIVES ACT.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—In the MEDICAL PRESS of June 21st you call attention to the dangerous muddle caused by those who insist that the poorer class of women shall be attended in their confinements by a very partially educated order of midwifery practitioner, while on the other hand the well-to-do are to have the highest skilled. In a philanthropic age this is strange legislation! Had Sir. V. Horsley and Dr. Ward Cousins not deserted their side, and had they fought against this Bill; it would have run a bad chance of passing Parliament. I wish to call attention to a very grave defect in the administration of the Act—that is, to the inspection of midwives.

Rule 20 of the Central Midwives' Board provides: "The supervising authority shall make arrangements to secure a proper inspection of every midwife's case book, bag of appliances, etc., and when thought necessary, an inspection of the place of residence and an investigation of the mode of practice."

I am told that a very inferior kind of Inspectors have been so far appointed. My contention is that the inspectors under the Midwives Act should be medical practitioners. It will require at least £10,000 per annum to administer the Midwives Act in all its several parts. If the "Supervision Authorities" cannot administer the Act, then they should recommend its repeal.

I am, Sir, yours truly,
ROBT. R. RENTOUL.

Liverpool, June 25th, 1905.

SIR,—Your admirable remarks under above heading in last issue are worthy of being printed in pamphlet

TOTTENHAM HOSPITAL.

OPERATION FOR DISEASED APPENDAGES.—Dr. ARTHUR GILES operated on a single woman, æt. 24, who had been sent to the hospital by Dr. Angus Hunt. The patient gave a history pointing to pelvic inflammation, and according to her own account was suffering from appendicitis; it was, however, evident from Dr. Hunt's account of the case, as well as from the physical signs, that appendages rather than the appendix were the seat of the trouble. There had been an attack of exanthorrhœa presumably of gonorrhœal origin, some two months previously. On examination a considerable swelling was felt on the left side of the uterus and a smaller swelling on the right. On opening the abdomen there were numerous light adhesions in the neighbourhood of the tubes; these were separated and the swelling on the left side was then found to consist of a thickened and occluded tube and an ovarian cyst. These were removed without any difficulty. On the right side the ovary appeared healthy. The abdominal ostium of the tube was occluded, but the tube itself presented only a slight degree of thickening, and it was therefore decided not to remove the right appendages, but to endeavour to restore the function of the tube by making an artificial opening (salpingostomy). This was done by making a longitudinal incision at the distal end of the tube, and passing one or two sutures of fine silk, so as to unite the peritoneum to the mucous membrane on each side of the incision. The abdominal wound was then closed up by the usual three-layer method. On opening the cyst removed from the left side, it proved to be an ovarian dermoid. Dr. Giles said that theoretically conservative procedure were the ideal ones in dealing with uterine appendages; but in practice it was sometimes found that conservative measures led to a continuance of symptoms and to repeated operations. This was especially the case when the adnexa were affected by gonorrhœa. Every now and then, however, a case occurred in which it appeared justifiable to adopt conservative treatment even with a gonorrhœal salpingitis. In the present case it was evident that the attack of salpingitis had been relatively mild; the tubes were not distended with pus, and there was no indication of grave infection of the surrounding structures. There seemed reason to hope, therefore, that if the right tube were left behind it would not set up fresh mischief in the pelvis, and as the patient was a young single woman of 24, it seemed worth while, when leaving the tube, to leave it with a possibility of active function. For this reason he had opened up its distal extremity, suturing the mucous membrane to the peritoneum so as to maintain the patency of the new ostium. The patient made an uninterupted recovery.

It is reported that the late Baron Nathaniel Rothschild, of Vienna, left £850,000 to be devoted to the foundation of a sanatorium in the neighbourhood of Vienna for persons suffering from nervous affections other than epilepsy, insanity, and incurable spinal disease.

ONE of the most popular medical institutions in Glasgow is the Medical Golf Club. It was started three years ago, and the membership now numbers upwards of a hundred drawn from the medical men of Glasgow and the neighbourhood.

No less than fifteen van-loads of pulped fruit put up in barrels and tin cases were recently condemned by the sanitary inspectors of Stepney. The fruit was on the premises of the Eureka Preserving Company, Bow. It was in a decomposed and putrid state.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JUNE 28, 1905.

TUBERCULOSIS OF THE KIDNEY.

THE brilliant address of Dr. Howard Kelly, of Baltimore, delivered recently before the British Gynecological Society, stands as a monument to the excellence of modern American surgery. In his own special branch of surgery Dr. Kelly has established a world-wide reputation. His operation of supra-vaginal hysterectomy, for instance, is performed daily all over the world, and he has contributed largely in other important ways to the science and the art of his speciality. In no department, however, has he achieved a sounder reputation than in that dealing with tuberculosis of the kidney, the subject chosen for his recent able and masterly address. Readers of the MEDICAL PRESS AND CIRCULAR may congratulate themselves upon the full report which, by reason of our close association with the society concerned we are privileged to give verbatim. They will find therein a graphic picture of the present position of medical science with regard to the diagnosis and the operative treatment of renal tuberculosis, with many illuminating side-flashes upon various more or less closely connected issues. It would be a task of superogation in this place to attempt to discuss or analyse the material thus presented to our notice. At the same time there are many aspects of tuberculosis, even when it affects mainly or solely a single organ, that cannot fail to interest and concern medical practitioners in many diverse fields of practice. Henceforth, for instance, the consulting physician or the general practitioner in charge of a patient suffering from some tubercular affection will read urinary complications in another light. The difference between a hopeless and a curable condition is that between day and night. It is to the patient labours of many distinguished surgeons that we are indebted for the marvellous advances which

have brought the surgery of the kidney to its present pitch of perfection. In 1871, that is to say, thirty-four years ago, Simon extirpated the kidney and published his classical work on the subject. By slow degrees the true pathology and clinical history of the affection have been brought to light. In our own country the names of Knowsley Thornton, Morris, Newman of Glasgow, and Hurry Fenwick have become inseparably connected with this progress. Of much interest is the observation that this field of renal surgery was for a long time shut off from the surgeon by three serious errors. In the first place renal tuberculosis was seen by the pathologist only in cases of advanced or general tuberculosis, so that it was concluded the disease was either the local expression of a general condition or was invariably bilateral. Secondly, it was assumed that the disease of necessity involved more or less of the entire urogenital tract from its inception. Thirdly, it was further commonly assumed that the infection was of an ascending character and therefore ineradicable. The recognition of these errors has enabled the modern clinician to argue from sounder premises. To the average medical mind perhaps the most striking feature of the present position is the astonishing development of accurate diagnosis with regard to even the early stages of tuberculosis of so inaccessible an organ as the kidney. Bacteriology has been pressed into the service and in most instances where the disease is present is able sooner or later to afford positive evidence by demonstrating the specific pathogenic organism of tuberculosis in the urine. A remarkable illustration of the confident dogmatism of modern surgery is shown by the fact that the discovery of tubercle bacilli in the urine may impart an instant ray of hope into an otherwise hopeless case. But accurate diagnosis does not begin and end in the laboratory. By the aid of cystoscopy the surgeon is enabled to determine whether both kidneys are affected and if the disease be one-sided to say which kidney is the seat of disease. Nor is the progress of operative measures less remarkable and satisfactory. Dr. Kelly especially insisted upon the value of early and prompt nephrotomy. Without attempting to discuss the operative aspects of renal tuberculosis, attention may be drawn to a desperate and apparently hopeless case in which life was saved by a series of operations. The patient was emaciated, the bladder contracted, and the seat of an active universal cystitis. The first step was to make a large vesico-vaginal fistula. A tubercular kidney and thickened ureter were then removed and afterwards two portions of the bladder; the fistula closed, and the bladder irrigated and distended. Recovery in a case of this kind affords a striking illustration of the possibilities of modern renal surgery. The Gynæcological Society may be congratulated on having secured a distinguished contribution to the annals of contemporary surgery.

SPONTANEOUS GENERATION.

SENSATIONAL reports have lately appeared in contemporary journals. They relate that the origin of life has been at last discovered. With a wealth of ingenuity that only those ignorant of physical science could have brought to bear on the subject, the details of the discovery have been served up to tickle the palates of every class in the community from the crossing sweeper to the theologian. It is impossible for modern journalism to announce facts without embellishment, and equally impossible for it to observe a sane aspect of expectancy as to any consequences that may follow from the ascertainment of such facts. Indeed, it troubles itself little enough about the basis of fact at all, provided a good head-line or startling contents-bill may be rigged up. We are not old enough to remember the publication of the "Origin of Species," but we have failed to ascertain that that epoch-making book was accorded the dignity of the front page or leaded type by the journals of its day, and we are sure that Lister's work was not received with salvos of interviews and special reporters. The one great scientific discovery that received the attention of journalists early in its career, namely, Koch's tuberculin, has not yet recovered from the discredit which their premature and ill-advised "booming" conferred upon it. It is, therefore, with the desire to give Mr. Burke a fair hearing from the public that we deprecate most strongly the sensational stuff that has been filling the columns of newspapers for the last few days. If Mr. Burke's researches have revealed a method of producing living organisms from inanimate materials, they would have lost nothing in credit or stability if the knowledge of them had been confined to the Cavendish Laboratory and a select coterie of competent scientists for a year or two longer; if they merely indicate a new property of radium, any scientific value they possess will now be greatly discounted by the disappointment that will follow the demonstration of the nature of the bodies discovered; moreover, if there be any fallacy or error in the experiments, Mr. Burke will probably find his future career considerably hampered by these premature disclosures. The facts of the case seem surprisingly simple. Mr. Burke, who has been working for some years on the causes of the phosphorescence of cyanogen, turned his attention to similar properties which radium possesses in a higher degree than that body. In the course of this work he placed some radium in a test tube of sterilised broth, and was surprised to find in the course of a day or two that the broth contained certain microscopical bodies hitherto unknown. Sub-cultures of these bodies were made, and some slight multiplication was obtained, although the growth was far short of that which usually takes place when bacteria are cultivated. Moreover, traces of sub-division of the units were observed under the microscope. The fact that they are soluble in water would militate against

Notices to Correspondents, Short Letters, &c.

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

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 re-forwarding 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.

LINGUIST.—The terms poliphagic and pomophagic were introduced by Gegenbauer. The horse might be taken as a good type of the first, a dog of the second. Man has been classed among the first.

G. B.—On the first Hospital Sunday (30 years ago) the collections amounted to £33,000.

DR. H. (Dunbar).—In all cases of uræmia the superheated air treatment may be prescribed as a sudorific agent far in advance of the depressing and uncertain drugs usually administered.

A SUBTLE INFECTION.

The rather trite saying "A little knowledge is a dangerous thing" was, forcibly illustrated the other day in a ward of the London Hospital. A clergyman whose duty took him there to attend to the spiritual infirmities of the patients approached a rather severe surgical case with the remark: "I regret exceedingly that I cannot shake hands with you, my friend, but I have just been talking to a bad case of pleurisy."

DR. F. (Salop).—The term traumatic apoplexy is applied to cases in which apoplectic symptoms follow an injury to the cranium after a variable interval. There is a good article on it in the *Ætius de Medicis* for May 10th, 1905.

G. F. (Guy's).—The Herbert Spencer Lectureship was started by a Hindoo gentleman. Mr. Frederick Harrison delivered the first of the series at Oxford.

DOCTOR v. LAWYER.

The attempt to disparage the evidence of medical men in law courts is an everyday occurrence. Sometimes it takes an amusing turn, as, for example last week at the Brentford Police-court:

Solicitor: "Supposing a man had a lot of drink and he commenced dancing, would it get into his head or his legs first?"

The Doctor: "The drink or the dancing?"

Solicitor: "The Drink."

The Doctor: "I really couldn't tell you."

Solicitor: "But you are a doctor, you know."

The Doctor: "Yes, but I'm not a magician."

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JUNE 28th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. C. Ryall: Clinique. (Surgical.) 5.15 p.m. Mr. S. Stephenson: Ocular Therapeutics.

THURSDAY, JUNE 29th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Mr. T. Walker: Hæmaturia.

MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST (7 Fitzroy Square, W.).—5 p.m. Lecture: Dr. F. W. Price: Aortic Stenosis. (Post-Graduate Course.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Lecture: Dr. A. J. Whiting: Affections of Peripheral Nerves.

FRIDAY, JUNE 30th.

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

TUESDAY, JULY 4th.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Dr. G. N. Meechen: Loss of Hair: Its Causes and Treatment.

Vacancies.

Borough of East Ham.—Medical Officer of Health for the Borough and Medical Superintendent of the Connell's Isolation Hospitals, Convalescent Home, and Schools. Salary as Medical Officer of Health £300 per annum, as Medical Superintendent of the Hospitals and Schools £100 per annum. Applications to C. E. Wilson, Town Clerk, Town Hall, East Ham, E.

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

North Riding of Yorkshire Lunatic Asylum, Clifton, York.—Medical Superintendent. Salary £800 per annum, with furnished house and allowances. Applications to Robert Hobbby, Clerk to the Visiting Committee, 5 New Street, York.

Leeds General Infirmary.—Laboratory Curator. Salary £150 per annum. Applications to Thomas Blair, General Manager.

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

City and County Borough of Chester.—Medical Officer of Health. Salary £500 per annum. Applications to J. H. Dickson, Town Clerk, Chester.

Monmouthshire Asylum, Abergavenny.—Senior Assistant Medical Officer. Salary £250 per annum, with board, furnished apartments, attendance, and washing. Applications to the Medical Superintendent.

Cavan Union.—Medical Officer. Salary £100 per annum, with vaccinating, &c. fees. Applications to Joseph D. Grier, Clerk of Union. (See Advt.)

Appointments.

FOX, IDA E., M.B., B.S. Durh., Resident Medical Officer, Sherwood Forest Sanatorium, Mansfield, Notts.

MACGILVERAY, W. JACKSON HOOKER, L.R.C.P., L.R.C.S. Edin., &c. Medical Referee, Royal Liver Friendly Society, for Higher Broughton, Manchester and District.

MCMILLAN, J., M.B., B.S. Glas., Certifying Surgeon under the Factory and Workshop Act for the Shotts District of the county of Lanark.

WETHERED, F. J., M.D. Lond., F.R.C.P., Physician to the Hospital for Consumption and Diseases of the Chest, Brompton.

Births.

THORPE.—On June 24th, at 252 Liverpool Road, Highbury, London, the wife of George Thorpe, L.R.C.P., &c., of a son.

Marriages.

CHEESE-RYAN.—On June 22nd, at St. Matthias, Earl's Court, Herbert Filiceul, youngest son of James Cheese, M.R.C.S., L.R.C.P., to Alice Warren, second daughter of the late Jeremiah Ryan, of the Wynnad and Sivaguna, India.

HICKS-GRYLLS.—On June 21st, at All Saints' Church, East Finchley, Thomas William Hicks, M.D. Lond., L.R.C.P. Lond., M.R.C.S. Eng., son of Richard Hicks, Esq., of Hull, Yorks, to Cicely Peatrix, daughter of Thomas J. Grylls, Esq., of Park Gate, East Finchley.

YOUNG-GULD.—On June 24th, at Holy Trinity Church, Ayr, Andrew Young, M.B., C.M., to Sarita Agnes, eldest daughter of the late James Guld, Edinburgh.

Deaths.

ARNOLD.—On June 23rd, at the Platts, Watford, Herts., Georgiana Isabella, wife of the Rev. Henry Edgeworth Bicknell Arnold, M.A., some time vicar of St. Matthew's, Oakley Square, N.W., and widow of the late Francis Henry Wilson Esq., M.D., of Watford, aged 64.

KYDD.—On June 23rd, at Craighard, Port Glasgow, Athol Sydney, aged 5, youngest child of D. A. Forbes Kydd, M.B., C.M.

TURNBULL.—On June 22nd, at 7 Lansdowne Crescent, London, Alexander Turnbull, M.D., Inspector-General of Hospitals and Fleets E.N. (retired), aged 67.

ASSISTANCY WANTED with a view to ultimate partnership or sole charge by a practitioner doubly qualified, aged 31, who has filled the offices of Resident Physician and Surgeon to one of the largest Infirmaries, and has done a good deal of surgical work. London or Provinces immaterial.—Address, Edin., London Office of this Journal.

CAVAN UNION.

MEDICAL OFFICER WANTED.

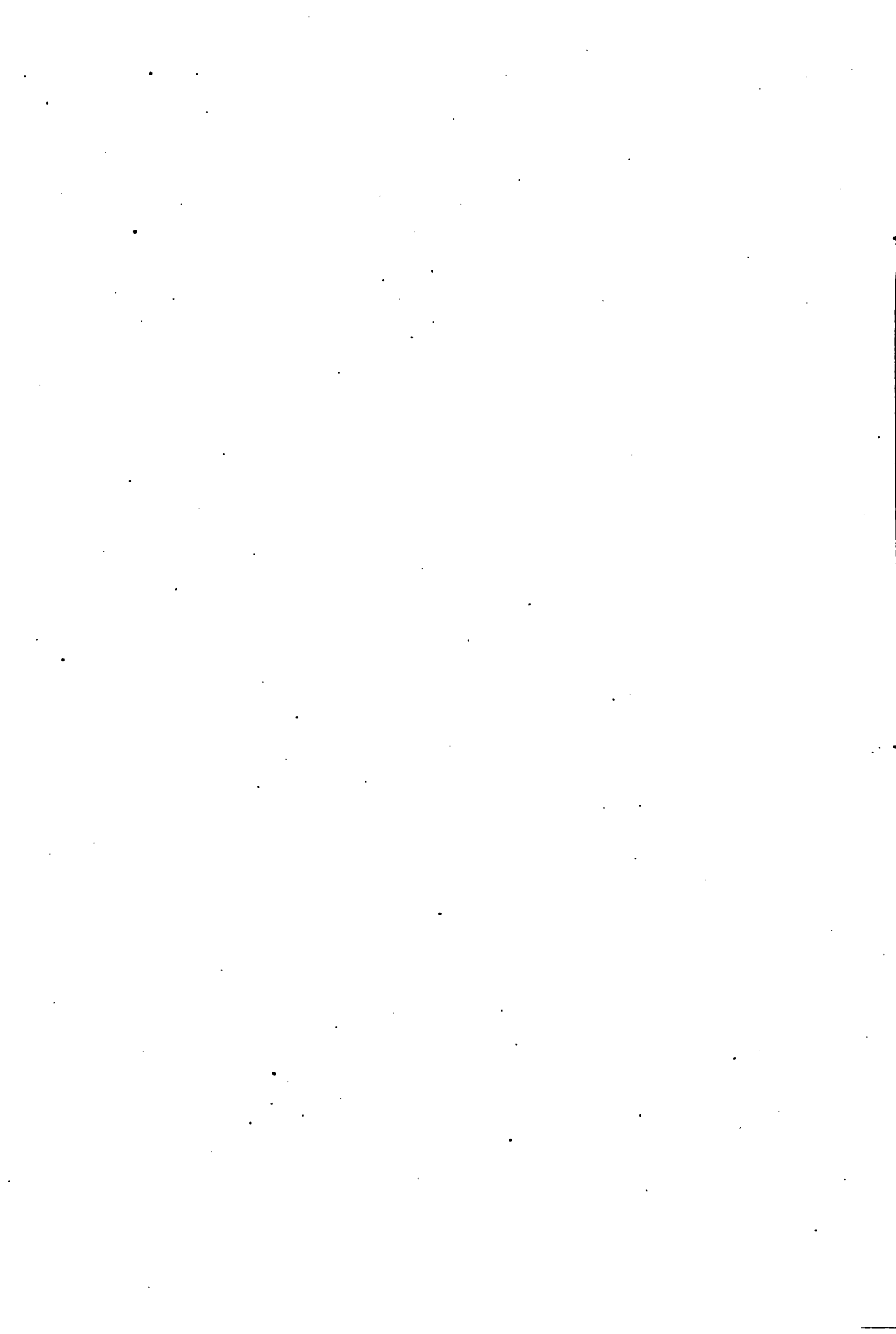
The Board of Guardians at their meeting on TUESDAY, the 11th JULY, will proceed to appoint a competent person to fill the office of MEDICAL OFFICER of the Bellanagh Dispensary District at a salary of £100 a year with vaccination and registration fees. The Rural District Council will also appoint to the office of MEDICAL OFFICER OF HEALTH at £20 a year. Candidates must possess the qualifications required by the Local Government Board. The person appointed must reside in the District. Seven days' notice of candidature to be forwarded to the Board. Proposals, with testimonials, to be forwarded by post prepaid and registered, and bearing the Cavan post mark not later than the 10th July.

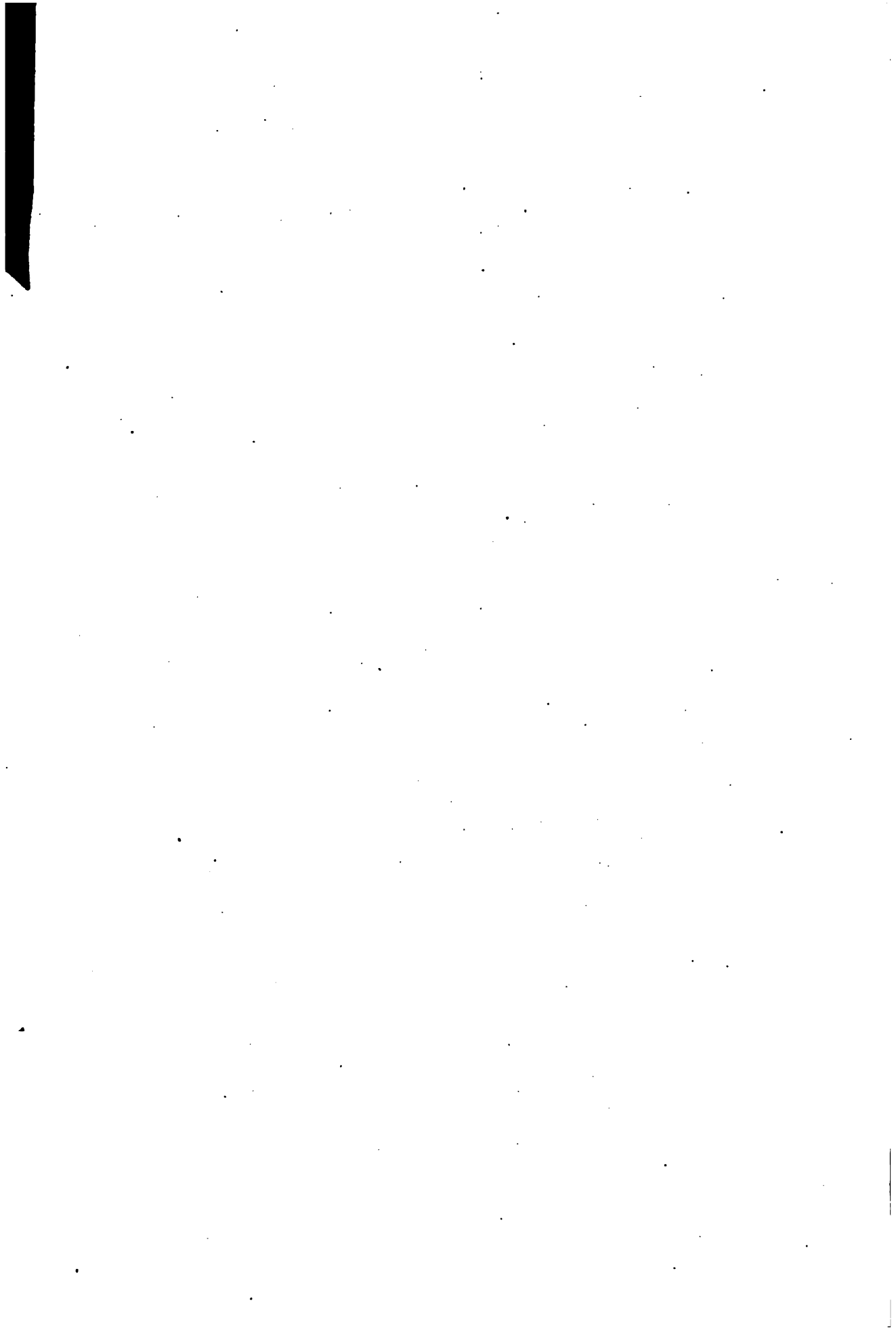
Cavan, 22nd June, 1905.

(By Order), JOSEPH D. GRIER, Clerk.

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